# PUBLIC HEALTH NURSING

*Official Organ of The National Organization for Public Health Nursing, Inc.*

VOLUME 30 JANUARY 1938 Number 1


WITHOUT any apology whatever we begin this brief message with the good old adage, "In union there is strength," because we believe with Hendrik Van Loon that proverbs are often statements of profound truths worn down to the fewest possible words by long usage. The truth of this old saying applies every bit as much to public health nursing as to any other human activity.

Why is there strength in uniting for more effective public health nursing? It is obvious that the N.O.P.H.N. is strengthened for its task of improving standards and concepts of public health nursing in just so far as it receives support from each of the public health nurses of the country and from each layman who is giving thought, time, and money to public health nursing. The N.O.P.H.N. rightfully needs the strength that comes only with united efforts.

But nurses and lay members of local associations, too, gain strength when they join forces with their national organization. Problems seemingly peculiar to your staff are well known to the N.O.P.H.N. Situations that seem so "different" find their counterpart in N.O.P.H.N. files, and questions for which you have never seen a printed answer may be under study this very moment at the N.O.P.H.N. office. No member of the N.O.P.H.N. need work alone! The N.O.P.H.N. is there to help you find a best way to reach your goal, whatever it may be. An individual gains strength in the use of such a partnership and from the intimate understanding of policies and practices denied the outsider. Yes, undoubtedly, the 10,000 members attested to the fact in 1937 that the individual as well as the N.O.P.H.N. gains strength in union.

Finally, there is the cumulative effect, the enhanced influence if you will, of more and more public health nurses and more and more laymen joining forces in a united effort to accomplish our goals.

To those nurses and laymen who remain outside of membership but who profit by the contributions made by those who join, we say: Come, do your bit! What you give will be returned in full measure and can never be realized by those who do not share in the struggle and the victory.

To those nurses and friends of public health nursing who are now members, we say: Let's *all* join forces! Let's make 1938 a year when we can say: Everyone I know in public health nursing is a member of the N.O.P.H.N.!

SOPHIE C. NELSON, *Chairman*
*National Membership Committee*

## "NEW YEAR"

"HAPPY NEW YEAR!" What mental images do these words evoke? Ask ten people and they will give as many different answers. "Father Time and Baby New Year," says one. "A gay time," says sweet sixteen. "A summing up," "an exchange of the old and outworn for the fresh and new," are more serious replies.

*An exchange.* This New Year thought has real significance in a profession which can scarcely keep pace with the rapidly changing needs and problems of its field. For it is only by a constant exchange of ideas, an exchange of ways of doing things, that we keep in touch with what is happening, profit by the experience of others, and keep in readiness to meet the problems of today—rather than those of yesterday.

Nor can such an exchange of ideas and methods be a casual matter—merely a so-called spirit of coöperation. To be effective it must be carefully planned. Various examples of such planning in local communities have come to our attention.

"Since we got acquainted with the health department nurses at joint staff meetings we work together just as if we were in the same organization," said a visiting nurse recently, in a city whose organizations have a definite plan of coördination. "We each know what the others can do and the results are much better service to the families."

Another public health nurse says, "We understand now what the social worker is trying to do and she understands us. Formerly we each made a different plan for the family. Now we have case conferences and exchange ideas on what can be done to meet the family's needs. Then one—or both—of us helps the family to make a plan."

And from another community comes this comment: "We need a nursing council in which our various agencies can plan together what is required to meet the needs of our own community."

Several interesting techniques of education through exchange are being used. Certain foundations award scholarships for an exchange of students between different countries, and for an exchange of ideas by allowing public health nurses in key positions to travel and observe what is being done in various places within the United States.

At least one state health department has evolved a unique plan for the exchange of theory for experience. Students who have had theoretical work are sent to a nursing agency for experience, and staff nurses in the agency are sent to college on social security stipends.

Another interesting plan is the exchange of supervisors, for a period, between hospitals and public health nursing agencies. The public health nursing supervisor learns what is happening in the hospital—new treatments and methods, and the resources which the hospital offers for service to patients in the community. The hospital supervisor sees the patient in his home environment and learns the use of community resources for meeting his problems.

Perhaps the most far-reaching channels of exchange in the public health nursing field are the national agencies. The N.O.P.H.N. itself was founded on this very principle. The early visiting nurse associations found themselves struggling along alone, learning by trial and error. First they began to exchange ideas informally with other nurses doing the same work. Then they felt the need of a national medium of exchange. Today the public health nurses and board members of the United States use the N.O.P.H.N. and the magazine as channels through which they keep informed of what is happening throughout the country, and share their experiences with one another.

Why not make 1938 a year of "exchange" in your community? P. P.

# A Rural Health Program in the Northwest

By LELAND E. POWERS, M.D.
Health Officer, Clallam County Health Department, Port Angeles, Washington

**The description of a rural health program which is developed through sound working relationships within the department and with community and state agencies**

EFFECTIVE working relationships are the basis for sound community service, and nowhere is this more true than in a rural health unit, which needs to utilize all of its resources to the fullest extent in order to meet its needs and problems. The relationship of the health officer in a rural health unit to his staff, and the relationship of the health department to various coöperating agencies within and outside of the area of the unit—these are vitally important to a successful program. The rural health program described here is therefore discussed primarily from the point of view of how these relationships are worked out.

Clallam County, Washington, has the distinction of being the most northwestern county in the United States. Bounded by the Straits of Juan de Fuca on the north and by the Pacific Ocean on the west, the county has a total area of more than 1700 square miles and an estimated population for 1936 of 21,500. Mainly mountainous and containing large areas of forest land, its chief industries are logging, pulp manufacture, and dairying. The county seat, Port Angeles, has an estimated population of 11,500. Several smaller towns and villages are scattered throughout the county. The only racial group offering special problems is the Indians, who comprise 4.12 percent of the total population.

A full-time county-city health department is maintained by Clallam County and the city of Port Angeles. The department is composed of a health officer, two public health nurses, a sanitarian, a milk inspector, and one clerk; and it has a new public health laboratory with a trained, graduate bacteriologist in charge. The Health Department carries on a program which is probably typical of an average rural health unit.

### PLANNING THE NURSING SERVICE

Programs are planned and discussed at staff meetings, which are held weekly for the entire staff. The general program common to any organized health unit is outlined by the health officer at the beginning of each year. However, the specific program of each staff member is worked out by the individual and submitted to the health officer for discussion and approval.

Special activities are planned in like manner and are worked into the general program so that very little extra time is consumed. After the programs have been discussed and outlined, they are presented to the local medical society, thus eliminating misunderstandings that might arise between the profession and the health department later. A few of these activities that are not exactly of a routine nature will be mentioned.

Each staff nurse is responsible for certain areas of the county and of the city. One day a week of the health officer's time is allotted to each nurse, in which to carry on activities which require the work of the health officer, such as immunizations, health examinations

of preschool, first-grade, and sixth-grade children, tuberculin testing, and educational talks to special groups.

Tuberculosis clinics are arranged at strategic points in the county following the Mantoux testing of the school children. At these clinics parents of these children who gave a positive reaction to the tuberculin tests are examined, and free roentgenograms are made. These clinics often find cases that are missed by the regular methods of case finding.

The Health Department has the direct supervision of a health camp on one of the local lakes, which is maintained throughout the summer mainly for malnourished children. The children are chosen for camp by the nurse or health officer from the schools during the year. The camp, which is free to children whose parents can not afford the fee, has a well trained director with experienced counselors in charge.

Health education classes are conducted in most of the secondary schools by the nurses, with specific lectures given by the sanitarian, milk inspector, and health officer. It is gratifying to note that the teachers, with the aid and stimulation of the health department, are gradually beginning to integrate health education into the general classroom subjects as well as just holding formal classes in the subject.

Such activities as biweekly venereal disease clinics where diagnosis, treatment, and medication are free to all, child care classes, syphilis educational programs, dental examination programs, demonstrations, and exhibits are common to most health units.

#### COORDINATION WITH SCHOOL NURSE

A school nurse, who is responsible for all school health work within the city, is maintained by the school board of Port Angeles. This nurse, who holds a certificate in public health nursing, coöperates very closely with the Health Department by attending all staff meetings, reporting her activities to the Health Department, and correlating her activities with the general program carried on throughout the county. One day each week of the health officer's time is allotted to the school nurse in order to carry out her program. With this plan of close coöperation she is considered practically as one of the staff nurses and works almost entirely under the direction of the Health Department. During the summer of 1937, she acted as camp nurse for the health camp previously mentioned.

#### UNIVERSITY PRACTICE FIELD

The Health Department coöperates with the School of Nursing Education at the University of Washington by taking students from the public health nursing course for field work. One month of the student's three-months' field work is usually spent in a rural health department.

During the first day of the student's visit to the department, the health officer outlines the functions and programs of the unit. As a part of her field work the student assembles a scrapbook containing a copy of each record used by the Health Department and an explanation of how it is handled both in the field and in the office, and works out an assigned problem dealing with the vital statistics of the local area, using graphs or tables as desired. Her work consists of three weeks of observation, and one week of visits under supervision.

The State Health Department acts in an advisory capacity for all local activities. In addition, the local department often requests aid in various special activities. For example, in one school where a high incidence of dental caries has been noted, an experiment has been worked out with the aid of the Dental Consultant of the State Department of Health, to determine whether artificially supplied calcium and vitamines will have any influence on the incidence of caries and delayed bone calcification.

The first six grades of this school were

chosen for the experiment and divided into three groups. The first group receives daily, from the teacher, fortified haliver oil and dicalcium phosphate tablets; the second group is given just the haliver oil; and the last group serves as a control. The children's teeth are examined monthly by the state Dental Consultant and each individual tooth is observed for the formation of new cavities or the enlargement of existing cavities.

At the beginning of the experiment the health officer examined the children with special notations on muscle tone, posture, skeletal development, and evidence of previous rickets. The wrists of each child were x-rayed at the beginning of the school year to note any delay in calcification, or other bone malformations. The wrists will again be x-rayed at the end of the year, and another physical examination will be given to note any change in development. The teachers are keeping accurate records of the number and causes of absences. All of the information collected for the three groups will be compared at the end of the year.

The state Dental Consultant also examines the school children's teeth yearly in areas in which a dentist is not available, noting cavities and other abnormalities. In areas where dentists are available, the dental society has undertaken this yearly check-up, with the aid of the nurses.

The nutritionist of the State Department of Health has aided the local unit materially in planning the diet and menus for the health camp during the summer. Members of the state department staff are called upon to give lectures at various meetings, such as teachers' meetings. The Health Education Division often assists in special educational programs such as the control of syphilis and gonorrhea, dental programs, adult education classes, and various other activities of an educational nature.

The Social Security Department has many activities which are closely related to public health work. For this reason it is imperative that social security and public health officials coöperate in the closest possible manner. The local Social Security Department helps in many ways, such as providing transportation to hospitals for remedial orthopedic surgery, providing transportation to diagnostic and consultation clinics, a blindness prevention program, a crippled children's program, child welfare services, and others. The department helps in a financial way also, such as providing fifty percent of the funds to operate the health camp during 1937.

The State Tuberculosis Association has been of inestimable value in carrying out a tuberculosis control program in Clallam County. The association conducts a tuberculosis clinic quarterly in the local health department offices with a trained chest diagnostician in charge, at which time contacts and minimal and suspicious cases are examined and valuable advice given. In addition, the local health department refers the doubtful cases, found in the clinics previously mentioned, to this more adequate clinic for final decision. In this way diagnoses are accurately checked.

Other agencies which aid the local programs directly or indirectly are the State Department of Agriculture and the Social Hygiene Committee of the State Medical Association.

#### VOLUNTARY AGENCIES INDISPENSABLE

The remedial program throughout the county is financed almost exclusively by voluntary agencies. It is true that the Social Security Department helps materially, but the bulk of the remedial work is financed by various other organizations. In the city of Port Angeles there is an Emergency Health Association which provides funds to take care of carious teeth and supplies glasses for defective eyes in children whose parents are unable to afford this work. The as-

sociation raises more than $1000 a year through campaigns and donations.

During 1937 a similar association was organized to do remedial work among the rural school children. The school nurse or a staff nurse—as the case may be—recommends the child for this service, with the aid of the health officer. Each case is cleared through the Social Security Department or by home investigation. The nurses or health officer approve the bills for payment.

The local chapter of the American Red Cross each year provides from one to two hundred dollars for remedial work which is recommended and approved by the Health Department.

Another fund known as the Beacon Bill Fund, which is similar to a community chest, provides a substantial amount for hot lunches in the schools and also for some remedial work. There are several other local organizations such as the Layette Club, Altruistic Club, and Friendly Neighbors Club, that help in providing mainly clothing, but also assist in the remedial programs. The parent-teacher association assists with the pre-school clinics, hot lunches, and educational programs. The local tuberculosis association pays for the x-ray films used in the diagnostic clinics. The Health Advisory Committee assists in many ways, as well as the county-city board of health, in formulating policies and programs.

This article has endeavored to show the relationships which are especially interesting to those engaged in that division which is the very foundation, the supporting backbone of public health—the division of public health nursing.

---

## KEEP YOUR GARAGE DOORS OPEN

You have already noticed that the engine of your automobile, after standing overnight in the garage, is less eager to perform than was the case during the warmer summer months. [During the] cold weather . . . the usual amount of "coaxing" and "warming-up" of the engine will be necessary before leaving the garage. Upon entering the garage, before any attempt is made to start the engine, be sure to see that the garage doors are open.

In a small garage with doors closed, an automobile engine generating a cubic foot of carbon monoxide per minute would, in a very short time, produce such a dangerous concentration of this gas as to render a person helpless.

Although many deaths have been reported from lack of this precaution, there are still persons who are unaware of the danger or who carelessly take the risk, thinking that they will feel some warning effect before they are overcome by the carbon monoxide in the gas generated by the running engine. Unfortunately, carbon monoxide gives no warning. The first noticeable effect is often muscular weakness which causes the victim to fall to the floor and renders him helpless. Unconsciousness soon follows. Unless he is discovered in time, death will result.

Remember to make certain that your garage doors are open before you start the engine of your automobile. If you know of anyone who has not been informed of this danger, please pass this warning along.

—*Connecticut Health Bulletin*, October 1937

# The Nurse Stimulates Employee Interest in Safety

By ERNEST AUGUSTUS
Safety Director, The Mead Corporation, Chillicothe, Ohio

**How can the industrial nurse help to maintain the interest of employees in the safety program? A safety director points out many ways in which she plays a strategic part**

THERE IS practically no limit to the ways in which an industrial nurse can be of help in arousing and maintaining employee interest in a plant safety program, if she has the proper personality, an enthusiastic interest in her work, sound technical training and ability to perform her duties properly, plus a generous supply of initiative and originality, and if management lends its active support to the program.

As each one, or all, of these essential qualifications may be lacking, to the same extent must it become increasingly difficult for the nurse to fit into the safety picture properly. In the first place, it is absolutely essential that the nurse be sold 100 percent on safety and the safety program.

### A JOB OF SELLING

Attracting attention to a particular thing or objective, arousing interest in it, and creating a desire for it to that point where the prospective customer is stimulated to take positive action in trying to obtain the thing desired—these are the fundamental principles of good advertising and successful salesmanship. Promoting employee interest in safety is primarily the job of advertising and selling an idea. To interest others we must first be interested ourselves.

Interest in safety is like a contagious disease; it spreads by contact. The industrial nurse, perhaps more than anyone else in the organization, can help insure uniform and effective spreading of interest. She should have sales ability of the highest order. To create and help maintain interest in safety, she must first create and sell good will.

She must be temperamentally fitted for her work. She should be slow to anger, assuming almost the hotel attitude that "The guest is always right." She must not close her ears to constructive criticism, but must let ordinary mumblings go over her head unnoticed. The employee must be the final judge of her ability to render service, and he is frequently a hard taskmaster. He is not easily fooled. He has a way of knowing whether sincerity prompts her actions.

### PSYCHOLOGICAL ABILITY

The industrial nurse should be able to understand the psychology of each employee who comes to her for treatment or who comes merely to seek advice or ask for information. She must never show any bias, and above all she must remember that each employee is different, psychologically, and that it is essential for her to adapt her approach in each case to the reactions of the employee toward his particular problem.

Presented before the Industrial Nursing Section, National Safety Congress, Kansas City, Mo., October 13, 1937.

The nurse makes a contact with the employee in a manner no one else in the organization is able to do, and frequently she may be able to give him bits of advice that will help him solve some of his most perplexing problems. By advising and reassuring the employee who has sought her assistance she can frequently relieve a worried mind; and putting a troubled mind at ease is often worth more than physical remedies.

Through her keen observation and sincere personal interest in the employee, she can gradually build up a feeling of confidence and good will which will go a long way in interesting the employee in her service and in the safety program of which she is such an important part. The employee will be encouraged to return for further treatment or to seek further advice and information, or perhaps to report some unsafe practice or condition which he has noticed.

### ATTITUDE OF NURSE

The industrial nurse must have a sincere interest in her fellow men, and a willingness to treat all alike. She should have professional dignity and at the same time a tolerance toward the workers which will not permit pettiness or gossip. She can retain this dignity and still be friendly and sympathetic, but not intimate.

She should have a sense of humor and a keen understanding of people. She should be eager to learn and to teach. She should be qualified in all respects to join the personnel director, the safety director, the company physician, and the various supervisors and foremen, as a member of the teaching faculty in the school of "human engineering."

### PROMPT ATTENTION

It is important that the wants of the employee be attended to as promptly and as gently as possible. Employees should never be kept waiting for a treatment or an interview any longer than is absolutely necessary. Five minutes can seem like an hour to the man waiting to have a cut finger or mashed toe dressed and bandaged. The longer he waits the more will he be likely to doubt the sincerity of the nurse's interest in his personal welfare and comfort, and the less likely will he be inclined to follow her advice or seek her assistance the next time.

The nurse must impress upon every employee with whom she comes in contact the fact that so-called trivial injuries must be cared for immediately. She should constantly stress the fact that the smallest wounds are large enough for thousands of germs to enter, and that infections can start within a very short time.

Another important point is the treatment of people who suffer slight injuries shortly before quitting time. These employees should be made to understand that they are to visit the first-aid room and receive treatment before going home.

### "HOW DID IT HAPPEN?"

Since men are more likely to talk about an accident and tell the real facts at the time the nurse is treating them than two hours after it has happened, the nurse has an excellent opportunity while giving a man first aid to get *his* story of how he was hurt. She may not learn from him the fundamental or underlying causes of the accident, but she can get a much better story from the injured worker's viewpoint than any other person in the plant. The very nature of her job inspires his confidence. He will talk more freely to her than to the foreman who may criticize him for participating in an accident, or to the safety engineer, who has an interest similar to that of the foreman and who likewise may be prejudiced.

While getting the employee's story, the nurse can diplomatically impress upon him the idea that carelessness does not pay. She can also draw from him his idea of what actually caused the acci-

dent and how similar accidents may be avoided in the future. The fact that someone has time to listen to his side of the story and is apparently interested in having his suggestions as to how a recurrence can be avoided, is bound to stimulate his interest in safety.

### USING INFORMATION

The nurse, without violating the confidence of the employee or involving him in any manner, can tactfully pass along the information thus gained to the safety director and others for further investigation and action.

The nurse should keep the foremen informed of the psychological reactions of those coming to her for attention. In this manner the foremen know better how to handle certain employees under certain conditions. Likewise, she should assist the company physician in making physical examinations and know the special conditions found in each employee. Then she can use her influence in getting employees to follow the doctor's advice in having certain conditions corrected.

The safety director should keep the nurse informed of his program and aims, so that she may assist him in his plans. In reality the nurse should be looked upon as an assistant to the safety director.

### SAFETY POSTERS

Many nurses find it advantageous to have a bulletin board in the treatment room, on which are displayed frequent changes of safety posters. A man looking at a bulletin-board poster in the first-aid department is likely to be in a more receptive mood than when looking at it on any other board in the plant. Many nurses have found it worth while to call the employees' attention to particular posters which she has selected for her bulletin board. Sometimes the nurse selects for display posters dealing with the types of injury most frequently treated by her. In this manner the safety posters are tied in directly with her work.

### KEEPING RECORDS

The keeping of records is another important function of the plant nurse. An accurate and complete record should be kept of every injury reported—when, where, and how it happened, and the treatment rendered, including redressings.

The employee who has been trained to realize the advantage of visiting the first-aid room and who knows a record is being kept of all such visits, cannot help showing a greater interest in safety than the employee who has not been so trained. His desire is naturally to keep his record as commendable as possible.

Records kept by the nurse can also be used by the safety director and department supervisors in helping to reduce certain types of injuries. Each minor injury should be looked upon as an accident. These should all be classified by types and causes for the use of the safety department, as a help to formulating new rules and general safety policies. First-aid records kept by the nurse might well be used as the basis for a systematic accident prevention program.

In this connection the nurse should be familiar with the records of various departments and should diplomatically call employees' attention, at the proper times, to either good or bad records. Similarly, if other forms of interdepartmental competition are fostered in the plant as a part of the regular safety program, the nurse should be familiar with the relative standings of various groups and should use her ingenuity in keeping the men interested in this competition.

Because she is constantly making contact with so many different individuals, the nurse should be thoroughly conversant with general company policies, and more particularly with those having to do with medical treatment, compen-

sation, and insurance. She is then in a position to answer employees' questions intelligently.

Another way in which employee interest in safety can be aroused is by showing the new employee through the hospital, pointing out various pieces of equipment, and explaining briefly their purposes. The nurse should also briefly explain the set-up of the medical department and the safety department, and the close relationship between the two, mentioning the methods used and the part the employee will be expected to play in helping the whole to function smoothly and efficiently.

The nurse can gain confidence and good will by familiarizing herself with the general layout of the plant, its principal operations, the manufacturing methods employed, and the products manufactured. She should have a working knowledge of the more important and hazardous pieces of equipment, the processes used, and the hazards involved, so that she may be able to talk the language of those who seek her assistance. To acquire this knowledge the nurse, accompanied by the superintendent, safety director, or company doctor, might well pay an occasional visit to each of the various departments of the plant, making a contact with the foremen or operators and asking questions.

When appropriate, both while going through the plant and when treating injured employees in the first-aid room, the nurse may inquire whether advantage is being taken of the various safety devices provided, such as goggles, safety shoes, respirators, and protective aprons. By knowing the plant, its processes and products, she can call the employees' attention to the importance of using the different safeguards.

First-aid classes for employees conducted by the nurse also stimulate an interest in safety.

Some experienced safety men are of the opinion that the plant nurse should serve on the plant safety committee, or at least that she should attend committee meetings. It is contended that in this manner she serves as an advocate of the injured worker's point of view during an accident analysis. It has also been suggested that because she may be better qualified to keep records than the others, she should serve as secretary of the committee. Regardless of the merit of these suggestions, it is agreed that the nurse should be kept closely informed of the activities of the safety committee, so that she may be able to discuss them intelligently with employees coming to her.

The nurse's influence may be extended to the community life of the town in which the plant is located, depending upon her willingness to participate in community activities, such as parent-teacher associations, community safety councils, and safety groups in the public schools.

If there is a plant publication, the nurse might prepare occasional articles dealing with safety and health. She should keep posted also on the latest developments in industrial nursing practices by reading nursing magazines and other literature on the subject. She should attend nurses' meetings whenever possible, as well as state and national safety congresses, thus keeping in touch with what others are doing in her field and getting a broader vision of her work and its possibilities.

In conclusion, the good industrial nurse should constantly bear in mind that she is engaged in the tremendously important task of "selling" good will. To be successful in this undertaking she must first interpret her work to those with whom she comes in contact. This is no easy task, but one not impossible of accomplishment provided she has the personality, the technical training, and the determination necessary for her work.

---

A news item of special interest to industrial nurses appears on page 51.

# New Jobs for Old

By ANNA L. TITTMAN, R.N.*

**What are the opportunities in the public health nursing field today? When should a nurse change her job? These and other questions are discussed by a vocational specialist**

A FEW YEARS ago no one would have had the temerity to speak upon the subject of new jobs for old, for then we were convinced that there was nothing new under the sun. In fact we felt that the sun itself had gone down (or out) forever! Jobs in nursing—both old and new—were so conspicuous by their absence, that as a vocational advisor I sank so low as to frame the phrase, "Any job is a good job." Today, Old Sol not only shines but smiles down upon nursing to the extent that good nurses—those with the proper degree of adaptability, knowledge, and skill—not only can find remunerative and interesting employment, but to a large extent they can be discriminating and pick their jobs. The demand for the well equipped nurse for the public health field greatly exceeds the supply. And in some parts of that field (I refer to certain specialties) not only is the right nurse for the work not found, but we know that she does not even exist. The employer, too, is being discriminating, which accounts for the fact that many public health nurses who have been unwilling or unable to meet advancing requirements are not acceptable to the community.

This is the day of expansion in public health nursing, even exceeding that immediately following the World War, and with it come new challenges, new opportunities, and new demands in equipment of the nurse. Because of the federal Social Security Act, which makes new sums available to state departments of health, the extension is obviously greatest in officially administered services, especially in rural areas. But private agencies as well, both rural and urban, are seen to be strengthening their programs, restoring personnel, and creating new positions. Through Social Security scholarships and through the nurse's own investments in preparation, the ranks have been greatly augmented, and yet there are not enough of the right type of nurses available. And if we may hope that one day every community will be served according to its need (which is something different than demand) we must triple the number, according to careful estimates of authorities.

## FROM THE OLD TO THE NEW

This subject would lend itself to dramatic possibilities were I to trace the history of public health nursing in the United States, with especial reference to job analyses. Perhaps some day an able artist may paint a frieze of this pageant of progress, or we may hope to have changes from old to new recorded in a scenario, depicting the romantic developments from pioneer to modern days.

*Presented before the annual meeting, Tennessee State Nurses' Association, Nashville, Tenn., October 12, 1937, prior to Miss Tittman's resignation as Vocational Secretary for Public Health Nursing of the Joint Vocational Service, to become Executive Director, Nurse Placement Service, Chicago, Ill., on January 1, 1938.

But we do not need this to make us aware of the significance of Dr. Thomas Parran's address at the N.O.P.H.N. Silver Jubilee dinner in New York City.* We need only to look about us to be convinced of the truth of his subject, "Public Health Nursing Marches On." This discussion is concerned not only with the increased activity in public health nursing, but particularly with the needs of the present situation in regard to:

1. Newer aspects of public health nursing, types of jobs, and points of greatest emphasis in present demand.
2. Some implications in regard to changing one's job.
3. The relation of personnel to community service.

### PRESENT-DAY DEMANDS

Concerning the present-day aspects of public health nursing, the chief point is that the element of teaching, long recognized as basic, has become more and more pronounced as part of every job. Teaching skill is the order of the day! School nursing, for example, is fast merging into a position with the title of teacher-nurse, and thence to the larger development of health educator. The supervisor in almost any type of service is rapidly gaining the title of instructing or educational supervisor. With the greater need for sound staff education and the increase of students in university public health nursing courses, there are new demands. Two important new types of positions fitting into recent developments in the field are that of educational director in state departments of health and that of instructor in public health nursing in university courses, with especial responsibility for the practice-field instruction.

Still another significant development in teaching that is growing rapidly is an obvious outcome of the new curriculum published by the National League of Nursing Education,* which advocates the incorporation of health and the preventive aspects of disease throughout the undergraduate period of study. The demand for instructors in public health nursing for schools of nursing has already become large. It invariably involves the responsibilities of formal classroom teaching in this subject, and also is concerned with bringing out the public health implications in every subject throughout the whole curriculum of theory and practice. Often, and especially in the smaller schools, this staff member may be more specifically connected with the out-patient department—sometimes as its supervisor, since this department presents unlimited possibilities for teaching student nurses and also patients, the preventive aspects of disease. And it is safe to predict that in time every instructor and every hospital supervisor and head nurse will be required to have public health nursing as part of their equipment.

For all these newer types and aspects of positions, a broad scope of experience and sound equipment in the field of education are requirements and we do not have the prepared personnel to meet the demand of today. This demand will grow like a mushroom! It behooves the nurse whose interests and potentialities fit into the new possibilities to meet the challenge!

By demonstration and experiment throughout the past decade we have proved to ourselves the advantages of generalized community service over specialized service. Through recent concentration on specific sore points in our nation's health record, there is a swing back to specialization in three major aspects of service—maternity, social hygiene, and orthopedics. This specialization is specifically for supervisors and

*Parran, Thomas. "Public Health Nursing Marches On." PUBLIC HEALTH NURSING, November 1937.

*Committee on Curriculum of the National League of Nursing Education. A Curriculum Guide for Schools of Nursing. National League of Nursing Education, 50 West 50 Street, New York, N. Y., second revision, 1937.

consultants—though for staff nurses also in some instances. The plan is to have these phases integrated into the generalized program as soon as the staff nurse is ready to carry them safely and effectively. Nurses now equipped for these jobs are infinitesimal in number and jobs are going begging. Nor do we yet have adequate facilities for preparing nurses for these fields. The acceptable preparation is a generalized public health nursing background upon which the particular specialty may be built, or the reverse. Efforts are being made to enhance and improve training opportunities in all three branches, and stipends are being granted to cover the costs for tuition and maintenance for nurses. Often, however, it is deemed necessary to go back to basic instruction, in which so many nurses had only a smattering in their fundamental courses. And many more need to be brought up to date in modern treatments and procedures.

Still another challenge comes from the field of research. While as yet the demand is not numerically large, the place of the nurse is growing in recognition, and when the opportunity is presented there is no one to be found to fill it. Can we afford to ignore the chance to have nurses participate in studies where nursing is concerned, and do we not fully recognize that the direction of our future building must be based on research? It is important that nursing personnel in adequate numbers will be available for the future.

These trends are just a few of the more pressing ones. Interesting also is the relation of nursing personnel in the fields of mental hygiene, social work, nutrition, nursery schools, convalescent homes, college health services, homes for the aged, industrial health, and many other situations. Most of these call for dual preparation and specific traits of adaptability. Obviously there is ample opportunity for variety and interest in work.

As to specific implications in changing one's job, let us start by asking the question: when should a public health nurse change from one job to another? The answer is threefold.

1. When she has exhausted its educational possibilities for herself and feels there are no longer elements of growth in it.
2. When she has made a satisfactory contribution.
3. When she has remained long enough to justify her appointment.

Involved in these precepts may be a variety of other factors: the nurse's own recognition of inadequacy; her discovery that the job was not properly represented; failure of funds of the organization; inability to establish rapport; and personal or family emergencies. Nurses do not often run away from difficult situations. They see the challenge and they have pride. As a profession we have less of a reputation of being drifters than formerly. We have learned that stability is an admirable trait and one that employers invariably seek. But the nurse should not be encouraged to remain in a job that does not give her an opportunity to develop her talent. Nurses too often miss the chance for advancement or ignore the opportunity to give a larger service when they are ready for it because they prefer nearness to their associates, or perhaps the particular climate or environment is so attractive as to be the deciding factor. It is a question which each nurse must answer for herself.

How does one hear of new opportunities suitable to her interests and equipment? Through professionally sponsored vocational agencies which do an individualized, particularized, casework service, with the needs of standards in the field as much in mind as the welfare of the nurse. Such an agency offers its files as a depository for the workers' professional records. It serves as a kind of insurance for the day when a change becomes imminent.

Employers of nurses may be appre-

hensive that all this talk of opportunities will create restlessness among nurses, leaving their services stripped of workers. Vocational and placement work is somewhat like being a player at a checkerboard, moving the little disks here and there, sometimes backward, sometimes forward, on to the king row. But there are two safeguards in this procedure:

1. There is no skipping and double skipping as in checkers, but the advancement is rather one of steady progression. No fair employer will stand in the way of a worker advancing to greater responsibilities when she is ready for them.

2. The new job for the nurse may not be in another place. The new job may very well be her old job, into which she can integrate the newer aspects of service. How often we find that it isn't always the pasture on the other side of the fence that proves to be greener than the one we just left. A nurse's reputation depends on making good in each situation.

#### PERSONNEL AND COMMUNITY SERVICE

We know that a successful community service requires many things. A few of the essentials are sound organization; communitywide interest and representation in its government; adequate funds; a program fitting the needs; and leadership that is well balanced and wise and that has vision. Perhaps the most potent index for successful community service is, however, the calibre of its personnel. The workers are the keystone of the arch. Public health nursing has been completely wiped out of a community for a period of years because a nurse who did not fit the situation failed through lack of adaptability, though her knowledge was considered in the upper level. Sometimes, again, it is the lack of knowledge which is the cause of failure.

Another observation is that the public health nurse may be so zealous for results in her own program that she fails to take cognizance of the importance of dovetailing her work with that of the social worker, the doctor, the sanitarian, the school teacher, and other workers in the same situation. With the present-day expansion in community service this is a mistake occurring all too frequently. The nurse does not always get the full significance of her work as a part of the whole. Splendid work can be spoiled by one poor worker. The whole arch may be shattered if the keystone isn't exactly the right size and weight. To change the analogy, a service is like a chain that can only be as strong as its weakest link.

To summarize, placement and vocational work today takes into account an expanding field, with larger demands for well equipped nurses. It is concerned with encouraging individuals to prepare for the challenges of today and the future. It attempts not only to find the right nurse for the right work but it analyzes qualifications to fit them into specific needs. Jobs are not like garments which we may take off and put on at will, nor cast aside for good and all, in an attitude of "off with the old and on with the new." Each job, no matter what its level or responsibilities, adds to the sum total of the nurse's experience and is an opportunity to serve.

# Student Affiliation with a Public Health Nursing Agency

**Recommendations of the Subcommittee on Student Affiliation of the Education Committee of the National Organization for Public Health Nursing**

THE N.O.P.H.N. appreciates the fact that a growing demand is being made on public health nursing agencies to take part in the basic preparation of nurses by offering opportunities for student affiliation. The organization recognizes its responsibility for suggesting ways in which such affiliations may carry out the spirit and purposes expressed in the new Curriculum Guide.

Therefore the Education Committee of the N.O.P.H.N. has outlined recommendations to serve as a guide for nursing schools and public health nursing agencies which are contemplating an arrangement for student affiliation, and also for state nursing groups which hope to set up criteria for evaluating and approving opportunities for such affiliation.

It is intended that these recommendations shall be used in conjunction with the unit on Nursing and Health Service in the Family, in the *Curriculum Guide for Schools of Nursing* published by the National League of Nursing Education.

ELIZABETH FOX, CHAIRMAN
*Education Committee, N.O.P.H.N.*

Increasingly schools of nursing are seeking affiliations with public health nursing agencies as a part of the students' basic nursing education. Increasingly public health nursing agencies are being pressed with demands for providing student experience, demands often beyond their ability to meet well. In many communities this affiliation has been carried on successfully for a number of years between progressive schools of nursing of accepted standards and well organized public health nursing agencies. The program for the students has been carefully planned and has been recognized by the public health nursing agency as an education procedure.

However, in other places the affiliation has not always been so successful. Schools of nursing whose standards have not always met those set up by the National League of Nursing Education have sometimes requested an affiliation in order to supplement an inadequate curriculum. Public health nursing agencies have too often accepted students, when their own staffs were small in number or unprepared to undertake the supervision of a student program, sometimes for the purpose of getting the work of the agency done. This has been unfortunate for the student, for the school of nursing, and for the public health nursing agency.

Only when the affiliation is carefully planned for and carried out as an educational procedure does it prove a valuable experience for the student. The agency which undertakes to offer such an affiliation must be prepared to allocate a considerable amount of its supervisory and staff time to this enterprise and to have its own work correspondingly slowed up. Because of this, the agency has many times had to limit the number of students it can accept for affiliation. It seems advisable, therefore, that preference in accepting students

should be given to schools of nursing whose standards are in accord with those set forth by leading groups in nursing education.

Because of the need for wise selection both on the part of the school and the agency, the Committee presents the following recommendations, based on the thinking and experience of public health nursing supervisors and instructors who have had many years' contact with student affiliation programs. It is suggested that before an affiliation is made in any community the school of nursing and the public health nursing agency study these recommendations carefully and undertake an affiliation only when these recommendations can be fulfilled.

#### OBJECTIVES OF STUDENT AFFILIATION

"This experience is not designed . . . as an introduction to the social and preventive aspects of nursing, nor as a specific preparation for public health nursing. It is intended rather to round out the student's nursing experience by having her meet some of the more common situations found in family health work and giving her practice in dealing with these situations."* Primarily it should be considered as additional experience in the possibilities of including a health as well as sickness approach in nursing. The objectives of student affiliation are as follows:**

1. To secure experience in applying to the home environment and family situation the nursing knowledge and skills previously acquired, including teaching skills.

2. To become acquainted with conditions and methods of treatment which are found more frequently in the home than in the hospital, such as work with expectant mothers, well children, and convalescent and chronic patients.

3. To learn how to approach the family, how to adjust to the situations found in the home, and how to guide the family in their efforts to facilitate recovery and maintain health.

4. To gain a wider knowledge of the health and social factors in family and community life as they relate to the maintenance of health and to the causes and treatment of disease.

5. To secure some practice in the use of community health and social resources and an appreciation of the interdependence of these agencies.

6. To have the opportunity for observing and understanding individuals of different age groups in their family relationships as a basis for a wider appreciation of human problems.

#### PREREQUISITES FOR AFFILIATION

*The school of nursing*

The student should have her affiliation in her third year and should have had the following:

A. Prerequisites
   1. Academic education
      *a.* A student should be at least a graduate of a four-year accredited high school
   2. Services in school of nursing
      *a.* Medical and surgical nursing—five months, preferably more
      *b.* Obstetrics—three months, including delivery room and postpartum care of mothers and babies
      *c.* Pediatrics—three months
      *d.* Nutrition, theory and practice.

B. Additional desirable experience
   1. Communicable disease service
   2. Out-patient department—one month, including prenatal, and if possible, pediatric clinics
   3. Contact with the social service department of the hospital. It is important that the students have a knowledge of the functions and the operation of this department. It is suggested that this be obtained by (1) a definite plan of contact with this department throughout the entire curriculum by means of conferences in connection with the students' cases and family studies, or (2)

---

*Committee on Curriculum of the National League of Nursing Education. A Curriculum Guide for Schools of Nursing. National League of Nursing Education, 50 West 50 Street, New York, N. Y., second revision, 1937. p. 510.

**_Ibid._, pp. 512, 513.

a period of at least two-weeks' observation in the department.

4. Theory and practice in nutrition should include, in addition to a knowledge of the fundamental principles of normal nutrition, instruction in family diet in relation to cost.

Preference should be given to those schools which provide service in psychiatric nursing and also to those schools which carry out a definite plan to incorporate the social and health aspects of nursing throughout the entire curriculum.

*The public health nursing agency*

In order that schools of nursing may know what agencies are suitable for affiliation, it is recommended that some plan be made by the state board of nurse examiners in consultation with the National Organization for Public Health Nursing for the accrediting of those public health nursing agencies whose practices are in accord with accepted principles as outlined by the N.O.P.H.N.

A. Prerequisites for an agency offering an affiliation

1. An affiliation should be sought only with agencies whose practices are in accord with the generally accepted principles of public health nursing and with standards of practice as outlined by the N.O.P.H.N., as to:*

   *a.* Organization
   *b.* Qualifications of nurses
   *c.* Personnel practices
   *d.* Salaries
   *e.* Supervision
   *f.* Procedures and techniques

2. No public health nursing agency should offer an affiliation unless it is prepared to accept an educational responsibility for the student. Wherever an affiliation is offered there should be one person responsible for the student educational program. In the large agency this may be the educational director. In a small agency the affiliation should be offered only when the nurse in charge is qualified, can take the full responsibility for the students, and can carry out the program in accordance with the recommendations that follow.

3. The ratio suggested by the N.O.P.H.N. of supervisors to staff nurses is one supervisor to eight or ten staff nurses, including students. This ratio—which is a minimum if there are students—is influenced by the preparation and experience of the staff nurses and by the number of services carried by the agency.

4. Experience has shown that it is not desirable for an agency to carry a ratio of more than one student to three staff nurses, if it hopes to maintain a safe, unbroken service to the community and offer a real educational opportunity for the students.

5. The qualifications of personnel should, with few exceptions, meet N.O.P.H.N. qualifications for those appointed to staff and supervisory positions in public health nursing.

B. Type of organization

To date, most of the opportunities for student affiliation have been offered by visiting nurse associations with a generalized program. Experience has shown that the transition from hospital to home is made more easily by the student through the bedside service of the agency that offers a family health service. There is room for further experimentation in the field, however, by health departments and other agencies which meet these requirements.

**ARRANGEMENTS FOR AFFILIATION**

A. Health of the student

1. A physical examination should be made not more than three weeks before affiliation, with a report of any condition which might affect the student's health or the service. The examining physician should understand the reason for the examination and the nature of the service upon which the student is entering.

2. Immunization

   *a.* Vaccination for smallpox and typhoid fever within the previous three years
   *b.* Schick test, with diphtheria immunization if indicated

*See the following publications of the National Organization for Public Health Nursing:

Manual of Public Health Nursing. The Macmillan Company, New York, second edition revised, 1932.

Principles and Practices of Public Health Nursing—Including Cost Analysis. The Macmillan Company, New York, 1932.

Survey of Public Health Nursing. The Commonwealth Fund, 41 East 57 Street, New York, 1934.

The Board Members' Manual. The Macmillan Company, New York, second edition revised, 1937.

*c.* Dick test, where recommended by local health authorities

B. Length of affiliation
Eight weeks to two months in the senior year are recommended. Students should be introduced at regular intervals, thus permitting the public health nursing agency to plan a sequential program of instruction and practice.

C. Throughout the affiliation the student should not be on duty in the hospital.

D. Class work in the school of nursing should be arranged so that the student need not return to the hospital for this purpose during her affiliation.

E. An application blank for each student should be submitted by the director of the school of nursing and should include records of the student's educational background, nursing abilities, and personality traits, and a health record including a report of a recent physical examination.

F. The visiting nurse association should send the school of nursing an evaluation of each student, and a record of field experience and class work.

G. It is recommended that the public health nursing agency have frequent conferences with representatives of the school of nursing in order that the responsibility for the affiliation be shared and the programs of instruction be more closely correlated. To this end it is desirable that the faculty of the school of nursing should include representation from the public health nursing agency.

H. It is understood that the student should be maintained by the school of nursing during the affiliation. The public health nursing agency should be responsible only for transportation on duty and furnishing the bag and necessary supplies. The affiliating student should wear the uniform of the agency, or one acceptable to it.

I. It is desirable that a written agreement be made between the school of nursing and the public health nursing agency, covering the points discussed above.

### PLAN OF STUDENT'S EXPERIENCE

Certain general principles governing the instruction are suggested:

A. There should be a carefully outlined plan for introducing the student to the field which should include:
1. Observation of home visits with the staff nurse.
2. Demonstrations in the office or home. Some agencies prefer to give the demonstrations in the office with all of the equipment available. In smaller agencies it is sometimes more feasible to give the demonstrations in the home. When this is done the demonstration should be followed by an office conference.
3. Classes. Experience has shown that the necessary classroom instruction can be given in a period of from four to six hours weekly. Insofar as possible, theory should be correlated with practice.
4. Frequent individual conferences with the educational director and supervisors.

B. Group excursions should be limited and are valuable only when special preparation for them is made both with the student and with the agency to be visited. Visits to other community agencies are most profitable when made by the student in connection with a specific case that she is carrying.

C. While it is desirable for the student to become familiar with the various services offered by the agency, this is not so important as that the student should be given the opportunity to carry a few cases over a long enough period for her to study the interrelation between health, sickness, and the family situation, and to plan and carry out, with assistance of the supervisor, a constructive program of health instruction and supervision in those families. Better results are often obtained by the students with cases that present comparatively simple health and social situations.

D. It is desirable that the student make one family study during the affiliation.

E. The method of having the student assigned to a selected district to work with the staff nurse in that district has proved to be very satisfactory for both student and staff. It increases the student's sense of responsibility for the community program and gives the staff nurse initial experience in supervision. This plan must be protected by careful selection of the staff nurse and close supervision by the supervisor and educational director.

F. The public health nursing agency should accept the responsibility for continuous supervision of students. Home supervisory visits should be spaced at such intervals as will make it possible for the supervisor to evaluate and promote the student's progress.

---

This article is also published in *The American Journal of Nursing*, January 1938.

# How Rural Nurses Live

By EDITH M. ROSS, R.N.
Public Health Nurse, Owen County, Spencer, Indiana

**What are the satisfactions of rural work? Miss Ross discusses practical considerations of salary and expense, recreation and professional growth, and the important rôle of committee members in aiding the rural nurse to find her place in the social life of the community**

WHERE WOULD YOU rather work—in the city or in the country districts? Are rural nurses cut off from professional progress and social activities more than their city sisters?

According to the salary study made by the N.O.P.H.N. in 1937 the most frequent salary paid to staff nurses is $125 per month. This is true not only for the country as a whole but also for rural nurses employed by private agencies while those employed by health departments most frequently are paid $130 per month. In the Middle West the most frequent staff salary is also $125.*

Recently I gathered information from twenty-three other rural nurses in Indiana as to the cost of living, how much, if any, they could save, what recreational facilities their communities afforded and in what they themselves indulged, and the local professional organizations to which they belonged as well as the non-professional. While I am quite aware that the experiences of twenty-four nurses (including my own) is in no sense an absolute criterion of the conditions even in my own State of Indiana, yet I believe they present a very average picture and are well worth some study.

*Miller, Anna J. "Salaries of Public Health Nurses in 1937". PUBLIC HEALTH NURSING, June 1937.

Of the 24, there were 21 nurses who spent an average of $10 a week on room, board, and laundry. The remaining 3 each maintained a home shared by others. One of these made no estimate of her cost of living; the second an incomplete estimate; while the third reckoned the cost of supporting her home at $16.70 per week.

Twenty of the group questioned declared their living accommodations were comfortable; 3 admitted them fair, and one said hers were not modern. In regard to finding their living quarters, 17 did it for themselves, while the quarters of 4 were secured by members of the nursing committee. Of these, one changed to another place. Three of the nurses lived at home.

### SAVINGS

I have no information whether the cost of living was taken into account in determining salaries. However, 8 declared they were unable to save regularly. Various reasons were offered. Two said they had not worked long enough, 3 had homes to supppprt, 1 had just bought a car, and another was in debt. Only 11, less than half, were able to save anything aside from insurance premiums. The highest regular saving was $50 per month; the lowest, $10; the average for the 11 was $20.60 a month, or less than $250 a year. However, 22 of the 24 carried insurance.

Rents are undoubtedly lower in rural districts than in the cities. Food and laundry costs are probably about on the same level.

The cost of clothes, of course, is an individual matter, but usually the rural nurse plays a more intimate part in community social life than does her sister nurse in the city. Moreover, she, like they, must attend meetings and institutes. All these activities call for more clothes, and such clothes nowadays are more often bought in cities than in small towns. In other words, the nurse must travel to the larger centers of population to make such important purchases. Transportation is expensive. Because of her distance from cities, the rural nurse is in no position to take advantage of sales and bargains as can the individual living there.

Another very important factor in the cost of living for the rural nurse is the purchase and upkeep of a car. For the rural nurse *must* have a car. Gasoline costs are no lower in country districts. On the other hand, the wear and tear on her car is greater and the mileage per gallon less, owing to bad—sometimes almost impassable—roads over which she may have to travel. In my own experience I note that the cost of new tires when I am working in a district with many unpaved roads is no small item of expense. The amount of car allowance per mile is no greater for driving through rugged, unimproved country than for smoother travel. And it is almost impossible, in my experience at least, to keep within the bounds of the mileage allowed.

#### HOW DOES SHE PLAY?

The rural nurse, it appears, is not without a wide range of recreational facilities if she cares to use them. Twenty-four different ones were mentioned. Of these, swimming seemed the most common, for 18 stated they could indulge in it if they wished. Of these 18, only 8 used it, however, as a source of enjoyment. Theaters, movies, golf, horseback riding, tennis, hiking, dancing, parties, club activities, and the library received prominent mention; yet winter sports, bowling, and fishing were named also. The recreation to be found at lakes, parks, community centers, a country club, the dunes, Young Women's Christian Association, and a literary club were listed. Certainly the rural nurse need not be limited in her choice of recreation!

Yet what activities do our group of 24 really enjoy the most? Reading led, with 15 indulging in this pastime; 9 went to the movies; 8, as we have said, went swimming; 5 indulged in golf. Another was a member of a little theater organization; 1 liked gardening; 2 sewed; 3 hiked; 3 delighted in fishing; 1 went in for photography, and still another for piano playing. Driving, boating, the theater, picnics, clubs, bridge, tennis, and parties were mentioned. One declared she went outside of her county for recreation, another craved more than she had facilities for, still another admitted she indulged in none, while a fourth stated she went to bed.

#### MEMBERSHIPS

There were 15 memberships in professional organizations, while 9 belonged to none. Of these 9 only 2 belonged to any other organization, even non-professional.

In the non-nursing and local organizations, business and professional women's clubs claimed the largest membership—8 clubs, sororities, church societies, the Daughters of the American Revolution, and the American Legion Auxiliary were mentioned. But 12 of the 24 belonged to none of these.

Is the rural nurse lonely? It might seem that a great number may be since 50 percent of our group belong to no organization for enjoyment or mutual helpfulness in the community in which they work and have taken up residence.

Yet the town in which I have now resided for less than a year has been most hospitable and has astonished me by its kindly and friendly attitude. I know, however, that communities do differ in their reaction to the stranger who comes to work within their borders. In my own case I believe the social life that has opened up to me has been due in a very large part to the presence on my County Health Council of young leaders.

Sometimes this lack of social contact is the fault of the nurse herself. She is weary after the day's work, for public health nursing takes much out of even the youngest and most vigorous of us. Perhaps she is too tired to make any effort for herself. She may, as a part of a family, find too many demands made upon her for outside activities. She may even be self-sufficient enough not to care for them. Yet there are nurses who are hungry for the cheer of companionship. I have in mind two nurses with culture and personal charm, and with more than average ability, who are not included in the group studied. One admitted that for the first six months she was in a county she was so lonely she used to drive fifty miles to find recreation. The other bitterly complained of the lack of real friendliness in the town in which she lived.

### A LIBERAL OPPORTUNITY

Truly the nurse needs to become a part of the community life in which she works. The smaller the town, the greater are her chances. Soon she comes to know families, and her opportunities to study them and their connections, to learn the folklore and traditions, are far greater than in the city where the population is much more fluctuating. In rural life the nurse comes close to the joys and sorrows, the loves and hates of people, their problems and their reactions to the deeds and attitudes of their fellows. As she listens to their talk she can hardly fail to receive a liberal education in the study of human nature.

If from no other standpoint than this very intimacy with community life, I believe rural public health nursing has a definite advantage over that in the city. True, the hours may be longer, for the rural nurse can seldom call her time her own. Night calls may be infrequent, but they are not unknown. Saturday afternoons and Sundays may sometimes have to be given over to the needs of the sick. Yet through it all one comes very close indeed to the pulsing life of the community she serves.

Is the rural nurse cut off from professional progress because she works alone? Is it a disadvantage not to be a member of a staff with one's work mapped out in detail by a director? Is such lack of supervision apt to create an overlapping of projects and a program that is inadequate and not well rounded?

To all of these questions I answer "no". If the rural nurse has an adequate background she perhaps more than any other, has an opportunity, if she will but use it, to develop initiative and executive ability. She will not emerge fullfledged in these capacities save after long experience, much discouragement, and some anxiety. Given average ability, however, plus experience under qualified supervision*—if she will but toil and try, if she will resolutely profit by her mistakes, if she will give her problems thought—she will by her very lack of contact with constant supervision learn to think things out for herself, to fit into community life and be of service, to have a real understanding of the needs of the people about her.

---

*See "Minimum Qualifications for Those Appointed to Positions in Public Health Nursing—1935-1940." Reprinted from PUBLIC HEALTH NURSING, March 1936.

# Health Education Materials

By MARY P. CONNOLLY, R.N.
Director of Health Education, Detroit Department of Health, Detroit, Michigan

**The school nurse is frequently asked for help in securing health education materials. Miss Connolly suggests a rich variety of sources which can be used for such materials**

THE FIELD of school health education is so wide and includes so many groups of students at different educational levels that a single age group—the secondary school group—has been selected for discussion. Health education materials for the secondary school groups must be chosen with the understanding that we are dealing with young persons, most of whom have had some experience with situations in which health was involved. If the program in the elementary school has functioned at all, the student has received education which enables him to be familiar with personal practices relating to health, and to have established some attitudes about it.

The secondary school student is beginning to develop social consciousness which includes the community in which he lives. He is beginning to learn that he is part of a group much larger than that found in family or school life. The newspaper claims his attention; he hears much on the radio, and is piecing together these bits which make up adult living. How can we prepare him to fit himself into this pattern, and to enable him to utilize the facilities in the community for maintaining health and to learn to accept the newer advances as they come from the laboratories? If the purpose of education is to prepare youth to develop an open mind to an ever-changing world, the plan for health education must be directed toward the same end.

The first approach to developing an open mind is an understanding of the conditions under which we live. Every community teems with material for this education. How about the local water supply? A class may embark on a study of this vital commodity and dig up historical facts which will make the town a more interesting place in which to live, or inspire a critical attitude toward this and other health problems which affect all of the people. The same procedure may be followed in relation to the milk supply and food inspection. Food inspection naturally leads to a study of foods available in any given community, with costs and standards of living by which health may be maintained. Material for these studies may be obtained from the local health department, from government bulletins, and from marketing surveys.

### WHAT ARE MEDICAL FACILITIES?

The medical facilities of a community should be a consideration in education for health, in order that young people may learn to choose wisely in selecting medical aid. How about the number of hospitals in relation to the population? How may a person who has no money receive care? What arrangements can be made for those who can pay something but will require time to complete

Presented before the Department of School Health and Physical Education of the National Education Association, Detroit, Michigan, June 30, 1937. Published also in the *Journal of Health and Physical Education*, December 1937.

payments? Is there a hospital-insurance plan in operation? What are its advantages or disadvantages? This course of study will provide the students with an opportunity to visit institutions and to obtain literature which will be studied by the class.

When it comes to personal medical service, a great many people have no basis for judging the qualifications of the persons whom they employ to care for them when they are ill. The term *doctor* whether applied to a qualified doctor of medicine or to the numerous doctors of healing arts, means one and the same thing, to them. How may a qualified physician be chosen? The local medical society will provide information on legislation dealing with the registration of physicians and the standards by which certain physicians may be termed *specialists.*

### MAKE STUDY OF MEDICAL NEEDS

A plan may be made whereby the student studies the medical needs of a family. What are the advantages of antepartum care? What is meant by prophylactic baby care? When should children be vaccinated for smallpox and diphtheria? How many students in the class have been vaccinated against these diseases? How was the protection obtained? What are the advantages of a periodic health examination? What diagnostic means are important when one receives a health examination? The tuberculin test, the x-ray, and the Wassermann test, all are becoming household words and the student needs to know how to deal with them.

The health service in the school provides excellent material for health teaching. Each service will be of greater value if it is thought of as an educational tool and not only as a service being supplied by the schools.

The vital statistics of a community provide material for weeks of study of communicable disease. Teachers quite frequently shy away from statistics or make them dry as dust, leaving the student bored and uninterested. Vital statistics are the bookkeeping of the community—a record of the joys and sorrows of a people.

Most health departments publish annual reports in which the records of disease for a period of years are printed. In addition to this, weekly or monthly reports on current disease trends are available. Interest will not be aroused in many students if they are merely told that the tuberculosis death rate for the community is 50 per 100,000 population. Great interest may be developed, however, when the trend in regard to tuberculosis deaths is studied and the reasons noted. How about measles? Why do we have recurring epidemics of measles at regular intervals? What has happened in most communities to make typhoid fever a rare disease? Isn't it worthwhile to be aware of a case of smallpox? There is history filled with pathos and with high endeavor in the control of smallpox.

### SOURCE OF A TEACHING UNIT

In one Detroit school this year, an alert teacher used the present city campaign to eradicate tuberculosis, as a teaching unit. The Department of Health supplied material for a study of the tuberculosis problem in the city. The next step was to learn about the communicability of the disease, and the advances made in its early discovery and cure. Moving pictures and slides were used to show the actual damage to the body. The facilities for the care of the tuberculous were noted and the cost to the community estimated. A committee of the most popular members of the class was appointed to arouse interest in having each student receive a tuberculin test. It goes without saying that these young persons will be more alert to the problem of tuberculosis and will use modern means to deal with it.

One of the most interesting lessons we have used is one devoted to an evaluation of the advertising of so-called health products. Criteria were developed by which the students rated the importance of the products. This developed a critical attitude toward the extravagant claims made by advertisers and at the same time enabled the student to discover for himself just what is important in maintaining health. When a student learns to ask himself who advances claims for a product, and why they are advanced, and how these claims fit into what he knows about body functions, a critical attitude is established which will save him money and enable him to get the most from all of his purchases. The Bureau of Education of the American Medical Association publishes several booklets on quacks, nostrums, and extravagant claims for products, which are of great interest to most students.

Mental health may be developed during the trying days of adolescence by a wise presentation of causes of conflicts and discussions of social relations. Vague fears brought out into the open and discussed by a class will often dissipate causes of unhappiness in young people and will direct them into more healthful channels of living. An evaluation of satisfactions will enable students to see that they are not very different from each other, and will promote understanding which is a basis for mental health.

#### "WHY DON'T PEOPLE LIKE ME?"

In connection with mental health, the social problems of the adolescent are tremendously important. The student who asks "Why don't people like me?" is groping for a way out of a problem which may affect his entire life. A personality test worked out by the students helped one group of which I know. The students rated each other and rated themselves. The individual student was given the ratings which his associates gave him, and he compared this with his own rating. The results were interesting in that some of the shy, unhappy members of the class developed confidence in themselves from the rating given them by others.

The National Committee for Mental Hygiene* and government bulletins present excellent material for these discussions. The discussion, however, is the most valuable part of the lesson, because bringing these distressing problems into the open does a great deal to solve them.

Science courses offer an unlimited opportunity for health education that is fundamental. In our lifetime great advances have been made in health protection. Even during the last ten years, whole new fields have been opened. We have to remember, however, that these advances have been made in regard to the basic facts of body functioning and disease transmission; and if the student is to be prepared to accept medical and sanitary science as dynamic, ever changing and finding better ways for living, he must have some foundation by which he may appreciate the change.

Some of the insurance companies publish booklets and pamphlets which are excellent material for this education. One series, called *Health Heroes*, is particularly valuable for giving a background for scientific advances.** *Hygeia*, a magazine of the American Medical Association, is equally valuable. *Parents' Magazine* carries articles, simply written, which may be appreciated by secondary school students.

Courses of study and lesson plans must of course be developed according to the educational level of the students and the type of community in which the student lives. This is merely an effort

---

*50 West 50 Street, New York, N. Y.

**Metropolitan Life Insurance Company. Health Heroes. 1 Madison Avenue, New York, N. Y.

to emphasize the importance of preparation for the endless problems which the student will encounter as he goes through his later school life into college and into adult life. If he can be given some tools by which he may solve these problems, his health practices and attitudes will be those of the intelligent man rather than those which will lead him to accept the cults, quackery, and a vain search for health through fads.

The health education teacher must be a sympathetic leader who will encourage the students to study their own situations and to form ideas of their own wants and needs. Indoctrination leaves the student in the same position where many of us found ourselves after courses in physiology in which we spent hours learning the names of the bones and muscles, and following the travels of a drop of blood through the body. We may learn about the things which are supposed to be good for us, but if they have no relation to our wants, they never really become a vital part of us.

These suggestions may seem to impose a large amount of preparation on the part of the teacher. And they do. However, the vision of the teacher and her own preparation for healthful living will convey more to the student than any amount of formal teaching which she may do. If there are advances in health protection, she should know it, and it is her job to intrigue the interest of the students.

Russell Conwell, a Philadelphia preacher, earned enough money to start Temple University by repeating over and over, in various parts of the country, a sermon which he called "Acres of Diamonds." The gist of the sermon was that every back yard contains acres of diamonds in one form or another if we only look for them. The same may be said of materials for health education. They lie all around us, waiting to be picked up and used and made a vital part of some student's life.

# Councils on Community Nursing

## *A Step Toward Better Community Nursing Service*

By GRACE L. REID, R.N.

THE DEVELOPMENT, purpose, and program of the Joint Committee on Community Nursing Service have been discussed in editorials in the official nursing magazines from time to time. This committee, composed of representatives from the three national nursing organizations and non-professional members of social and civic groups, was organized with two main purposes in mind: (1) to analyze the need for more satisfactory nursing service; (2) to study ways and means of meeting this need. In working toward the accomplishment of these purposes, the committee hoped to be able to offer practical suggestions to any community which might request assistance in the solution of its problems.

Many communities have considered it feasible to study the activities related to the care of the sick and the problems that arise in carrying on such activities, through the organization of a representative local group, composed of both professional and non-professional members, and usually called a *nursing council*. Many requests for assistance in organizing councils have come to the Joint Committee on Community Nursing Service from other communities that have realized the need for a nursing council, but have felt the necessity for some guidance in outlining its purposes, objectives, and qualifications for membership.

In an attempt to furnish usable information which may be helpful in such a situation, a subcommittee of the Joint Committee on Community Nursing Service* presents the following outline, hoping that any group faced with the all too common problems in connection with nursing distribution at the present time, will find this material adaptable to its needs.

### SUGGESTED GUIDE FOR THE FORMATION OF A COUNCIL ON COMMUNITY NURSING

#### I. INTRODUCTION

A council on community nursing service should be composed of representatives from all elements in the community interested in nursing. Its purpose is to promote the best possible nursing service for the community, through studying the nursing needs and methods for meeting these needs, and through promoting adequate preparation of nurses for such service. This guide attempts to show the steps which should be taken in forming such a council.

Usually a small group in a community first becomes aware that nursing service is inadequate to meet all the needs. This group may represent users of nursing services, nurses themselves, or some allied community group. They talk over the situation and gradually a number of people may realize the problem. Then a meeting representing all interested groups may be called to form a committee for discussion of community needs. Representatives from the recognized local medical and nursing organizations should be included from the beginning. Points outlined below under "II. Analysis of the Situation" may form a basis for discussion.

The committee may form a more or less permanent council on community nursing at once and then proceed to work out measures for providing more adequate nursing service. Sometimes, on the other hand, the committee decides to begin with a survey of nursing needs and facilities for meeting them, and con-

*Miss Reid is chairman of this subcommittee.

tinue as a committee for this purpose. Such a study almost inevitably shows the value of a council on community nursing and should result in its formation. Local conditions and opinions will determine which order of procedure should be followed. In either case, analysis and study of the local situation are important.

**II. ANALYSIS OF THE SITUATION**

A. Community problems which show the need for study

1. Sick people without nursing care
2. Dissatisfaction regarding the quality of nursing service available
3. Difficulties in meeting the needs, as expressed by nurses, doctors, hospitals, and representatives of the public
   - *a.* Cost of nursing service prohibitive in some cases
   - *b.* Conditions of employment not always satisfactory
     - (1) Hours too long
     - (2) Salaries too low
     - (3) Living conditions not conducive to good service
   - *c.* Distribution of nursing service may be uneven
     - (1) Gaps in and duplication of services because of too many agencies; services not entirely covered by any one agency
     - (2) Inefficiency of the registry
   - *d.* Lack of integration of service
4. Confusion on part of public when situations arise which require nursing service
   - *a.* Names of agencies confusing and often misleading
   - *b.* Multiplicity of agencies
   - *c.* Functions of agencies not well understood by general public
   - *d.* Procedures for obtaining help not generally understood

**III. AREA SURVEY**

A. Purpose: to collect information and to make recommendations regarding:

1. Types of nursing service offered
2. Types of nursing service needed
3. Preparation of nurses required to furnish these types of service
4. Distribution of nursing service
5. Relationships among all agencies offering service
6. Use of subsidiary groups such as "practical nurses," attendants, and visiting housekeepers

B. Method of surveys*

1. Direction
   - *a.* Executive committee. A small executive committee of representative citizens and nurses should be appointed to supervise and guide the survey.
   - *b.* Director. If possible some qualified person outside of the community should be engaged to direct the survey
2. Participating groups should assist in collecting data and should include:
   - *a.* Agencies distributing nursing services
     - (1) Nursing bureau or registry
     - (2) Hospital nursing services
     - (3) Public health nursing agencies
       - (*a*) Official:
         Department of health
         Board of education (if it maintains its own school nursing service)
       - (*b*) Public health nursing association
         American Red Cross chapters
         Tuberculosis associations
         Others
   - *b.* Schools of nursing and educational institutions giving courses which prepare nurses for community service
   - *c.* Medical profession
   - *d.* Hospitals (hospital council, if there is one)
   - *e.* General education group
   - *f.* Social service agencies
   - *g.* Public at large
   - *h.* Statisticians. Often there are local people with this preparation who can give some time and should be able to render very valuable assistance in making the survey.

C. Financing the survey**

---

*Assistance in making a community survey may be secured from the Joint Committee on Community Nursing Service (of the three national nursing organizations), 50 West 50 Street, New York, N. Y. Assistance in studying specific problems may be secured from the three national nursing organizations: *i. e.*, registry or nursing bureau development, from the American Nurses' Association; schools of nursing, from the National League of Nursing Education; public health nursing, from the National Organization for Public Health Nursing. All three are located at 50 West 50 Street, New York, N. Y.

**An area study or survey of nursing needs and facilities is of sufficient importance to merit financial support of interested individuals and groups in the community.

1. The cost of an area study or survey would depend upon:
   *a.* The side of the area to be studied
   *b.* Number of agencies rendering service
   *c.* Extent of survey
   *d.* Amount of expert assistance from outside the area, and the distance an outside person would need to travel to reach the community, the length of time spent there, transportation and maintenance within the area, and other incidentals
   *e.* Clerical help
   *f.* Amount of work done by local groups
   *g.* Other incidentals
2. Sources of income—may be from gifts and subsidies
   *a.* Community chest
   *b.* Individual agencies
   *c.* Professional organizations
      (1) Nursing association (district or state)
      (2) Medical society
   *d.* Foundations
   *e.* Community-minded citizens

D. Information and publicity:

If the area survey precedes the organization of a council on community nursing, a small committee should be appointed and held responsible for publicity on what is being done. It is understood that any publicity released should be previously approved by the executive committee. If there is a trained publicity person in the community who is interested in nursing it would be very valuable to have him on this committee.

1. Methods
   *a.* Short radio talks
   *b.* Newspaper articles
   *c.* Reports or short talks to interested groups
   *d.* Inclusion of wide representation on committees and subcommittees
2. Materials
   *a.* Facts and recommendations of study
   *b.* Graphs and posters
   *c.* Bibliography (Bibliography may be secured by writing to the Joint Committee on Community Nursing Service, 50 West 50 Street, New York, N. Y.)

E. Recommendations

These should form the basis for further study, and if the study has been done first, it is expected that the recommendations would include suggestions for the formation of a council on community nursing.

## IV. COUNCIL ON COMMUNITY NURSING

A. Purpose: To provide the best possible nursing service to the community

B. Objectives (Adapted from summary of panel discussion of the Nurses' Association of the District of Columbia)

1. To provide a meeting ground, through broad representation, for the discussion of matters affecting nursing service from the point of view of the public served as well as that of the nurse giving the service
2. To give opportunity to study various problems from the point of view of all concerned, rather than from the viewpoint of one isolated organization's needs
3. To serve as a connecting link between the community, the agencies that provide nursing service, and the nurse who gives the service, and thereby establish sound public relations
4. To encourage the setting up of proper machinery to coördinate and distribute nursing service in a community so that there will be a minimum of waste
5. To sponsor new types of programs of nursing service
6. To interpret nursing to the community
7. To interpret community needs for nursing service to:
   *a.* Schools of nursing
   *b.* Agencies distributing nursing service
   *c.* Individual nurses rendering such service
8. To insure adequate preparation for nurses for community service
9. To stimulate the feeling of responsibility:
   *a.* On the part of the community for:
      (1) Supplying nursing service to the community
      (2) Education of nurses to render the service
   *b.* On the part of the individual nurse for the quality of service that is given
10. To stimulate interest and provide ways and means for research on mutual problems
11. To furnish a means of education for various groups concerned

C. Suggested steps in the organization of a council on community nursing:

If an area survey has been made, plan C-1 below may be followed. If the organization of a council on community nursing is to precede an area survey, plan C-2 would be wiser.

**PLAN C-1**

In plan C-1 it is assumed that the group invited to organize a council on community nursing is already conversant with the previous discussions on community nursing problems. It is also assumed that the endorsement and approval of the district (or state) nurses' association has been secured.

Preliminary to the meeting which will be called for the purpose of organization, notices should be sent out asking the representatives of the various agencies to secure the approval of their boards of directors for the organization of a council on community nursing.

Suggested procedure at organization meeting:

1. Call to order (by the person who called the assembly)
2. Statement of general purpose of the meeting
3. Election of temporary chairman
4. Election of temporary secretary
5. Adoption of resolution that council be formed (Follow usual parliamentary procedure for motion, discussion, and vote)
6. Appointment of chairman of committee to draft by-laws
7. Appointment of chairman of a committee to submit a ballot for permanent officers
8. Choice of date, hour, and place of next meeting

**PLAN C-2**

Preliminary meeting:

When the formation of a council on community nursing precedes an area survey, representatives from the various community groups should have an opportunity to discuss the various aspects of community nursing and the functions and need for a nursing council. They would then need to discuss with their own agency groups the proposal of organizing a council on community nursing and secure their approval. A small group of interested persons may invite representatives from all the interested community groups to a meeting for the purpose of the above-mentioned discussion.

Follow same procedure as in plan C-1 beginning with item I.

## SUGGESTED BY-LAWS

### Article I

Name: Council on Community Nursing (or other name as desired)

### Article II

Purpose: To provide the best possible nursing service to the community (May be more specifically stated to fit particular needs if desired)

### Article III

Membership:

A. Representatives of all nursing service agencies. These should include executives and board members
   1. Nursing bureau or registry (professional)
   2. Hospital nursing service
   3. Public health nursing agencies
      *a.* Official
         (1) Department of health
         (2) Board of education (if it maintains a school nursing service)
      *b.* Non-official or private
         (1) Visiting nurse association or public health nursing association
         (2) American Red Cross chapter
         (3) Insurance company visiting nurse service
         (4) Others

B. Representatives of nursing education field
   1. School of nursing represented by principal and member of school committee
   2. Department of educational instruction giving courses in nursing education, represented by director

C. Local professional nursing groups
   1. District
   2. Local league of nursing education (if there is one)
   3. Local branch of state organization for public health nursing (if there is one)

D. Lay public—Representatives selected from interested influential citizens. This group should comprise about one third of the membership and should be composed of people keenly interested in community affairs

E. Allied professional groups—representation selected from:
   1. Medical society
   2. Hospital group through hospital council
   3. Health department—health officer
   4. Social service groups through the council of social agencies
   5. Field of general education

### Article IV

Officers: President (preferably a lay person), vice-president, secretary, and treasurer

### Article V

Committees:

A. Executive
   Four officers and chairmen of the standing committees

B. Standing committees
   1. Finance
   2. Nominating
   3. Program
   4. Revision and membership
C. Others as necessary, such as
   1. Public information
   2. Research
   3. Legislative

**Article VI**

Meetings:
A. Full council meeting held quarterly or on call
B. Standing and special committees meet regularly and as needed

Other articles which may be added may include:
Methods of election
Length of term of officers
Duties of officers
Appointment of committees
Notice of meetings
Quorum

---

NOTE: This form is being offered only as a suggested guide and not a form to be followed. It is expected that every community presents problems and situations that make it impossible to fit into a set pattern. For example, in some communities it might be wise for certain reasons to limit the representation from each agency (See Article III, Item "A."). The board of health might have a citizens' advisory committee which should be represented.

The following reference will be helpful in preparing the by-laws: Fox, Emma A. Parliamentary Usage. Doubleday, Doran and Company, Garden City, New York, 1934.

Help and assistance in an advisory capacity may be secured from the Joint Committee on Community Nursing Service, 50 West 50 Street, New York, N. Y.

This article is published in *The American Journal of Nursing*, January 1938.

*By M. M. Nellis, Topeka, Kansas*

# Arizona Plans for Its Crippled Children

By RUTH E. WENDELL, R.N.
Director, Crippled Children's Division, Arizona Board of Social Security and Welfare

**In the face of tremendous physical and economic difficulties Arizona develops a program for its crippled children**

ORGANIZED efforts in behalf of crippled children in the State of Arizona are of very recent origin. Prior to the organization of the Society for Crippled Children in 1929, nothing was done for this group outside of Phoenix, where the Social Service Center conducted weekly orthopedic clinics for handicapped children living within the city area.

The Arizona Society for Crippled Children raised funds in 1929 for the purpose of making a statewide survey to determine how many crippled children there were in the state and what facilities were available for their care. Funds were exceedingly limited and it was impossible to carry on this activity beyond the larger centers. Nevertheless, the results of the survey created an intense interest in the problem of the crippled child.

The Society carried on its work for a period of three years, supported by service clubs, lodges, civic and other lay groups, and individuals. During this period approximately 1000 crippled children were located, but the facilities for their care were found to be limited. Individual orthopedic surgeons within the state gave generously to the cause since there were no funds with which to pay for service. Outside of the state the Shriners' Hospital in San Francisco and the Orthopedic Hospital in Los Angeles assisted greatly in the program. However, economic conditions in 1932 were such that it became impossible to raise sufficient funds with which to carry on, despite the interest. Crooked limbs and backs became of secondary importance when the greater need was for bread, and the work was discontinued with approximately 200 children having been given treatment.

With the provision for services to crippled children under the federal Social Security Act in 1935, interest in this group was quickly revived. The Arizona Board of Social Security and Welfare was designated as the agency to carry on the work and a plan was submitted to United States Children's Bureau. Arizona was among the first eleven states to have its plan for services for crippled children approved by the Children's Bureau.

### PROGRESS IN 18 MONTHS

Immediately upon acceptance of the Arizona plan, activities began in all earnestness. While a series of diagnostic clinics was being held throughout the state, one of our larger hospitals began a reconstruction program. As a result it now has a very modern orthopedic department, including a physical-therapy division with a pool and the necessary equipment for all types of treatment. A second hospital in the state has also established an orthopedic department and is increasing its facilities as rapidly as possible.

A new county hospital in one of the treatment centers has added its contribution by providing a sixteen-bed orthopedic ward and a very adequate physical-therapy and out-patient department.

This same community, since the beginning of the crippled children's program, has also built and equipped a fifteen-bed convalescent home, with graduate nurses in attendance. In addition, arrangements have been made for giving convalescent care to another group of fifteen, also with a graduate nurse in charge. In the other large treatment center no convalescent home is available, but foster-home care has been arranged for about twenty-five children in homes of graduate nurses.

With these facilities available, all developed within the past eighteen months, it has been possible to stimulate field activities far more rapidly than was thought possible at the beginning of the program.

#### MANY HELP IN CASE FINDING

Arizona has no provision for taking a school census through its educational system, nor are congenital deformities or birth injuries systematically reported. However, through the united efforts of the State Departments of Health and Education (the latter with its Vocational Rehabilitation Division), the public health nurses, the workers in the County Boards of Social Security and Welfare, the Indian Service teachers, mail carriers, and other interested individuals and agencies, 1703 children have been referred to the Crippled Children's Division. Of this group approximately 650 cases have been cleared, and those who can be helped are either receiving care or are awaiting their turn.

These children are being cared for in five treatment centers located in various parts of the state where orthopedic surgeons and hospital facilities are available. In only two centers, however, are hospitals adequately equipped for all types of orthopedic treatment, and selection of the treatment center is based on the need of the individual child.

The members of the last legislature, recognizing the great need for care of these children, more than doubled the state's appropriation for the second fiscal year for this phase of the social security program. These additional funds will not only make possible the care of a greater number of children during the coming year, but will also stimulate greater effort on the part of public health nurses and social workers.

Arizona, the fifth largest state in the Union, has only fourteen counties, a fact which helps to simplify the organization activities of the Crippled Children's Division. There are no political subdivisions under this program and all activities are directed from the state office. However, each County Board of Social Security and Welfare is responsible for obtaining and forwarding to the state office the social history and forms, which must be signed by the parent or guardian of every eligible child in its county.

Responsibility for transporting children to and from treatment centers has been assumed largely by service clubs and other organized groups, including committees of the President's Birthday Ball. These groups have also assisted in paying for special shoes, braces, convalescent care, tonsillectomies, and other treatments of a non-orthopedic nature for children who are receiving services within the Crippled Children's Division.

Diagnostic and advisory service is available to every crippled child from birth to twenty-one years, regardless of the economic status of the family. Treatment is provided only for those who are unable to meet its cost even under a lenient repayment plan. Parents who are financially able are expected to assist in the payment of the cost of treatment to the best of their ability, usually on a monthly basis. The funds thus returned are credited to the Crippled Children's Division and help to extend its service.

There are in the state approximately 193 field workers, public health nurses and social workers. Of this group, 71 are public health nurses, 31 of whom are affiliated with state and county departments of health, and 40 of whom are school or community nurses. The nurses who are affiliated with the departments of health either have their public health nursing certificates or are being sent away for public health training on scholarships available under the provisions of the Social Security Act.

Distances are so great and the duties of these groups of workers so numerous that frequent home visits are almost impossible in certain sections. Workers in one county actually have to enter both California and Utah in order to reach a certain section of the state In some instances it has been advisable to bring parents to the treatment center where they have been taught how to give the necessary home care.

It is upon the field workers, however, that the state division must depend for local contacts. They assist in locating the children and in arranging for their examinations and treatment. The public health nurses are responsible for the follow-up care and general supervision of the child after he returns to his home, in counties where public health nursing service is available. Both nurses and social workers are also doing much to stimulate local interest and community responsibility for these children, emphasizing educational needs, vocational training, and social adjustment, as well as physical care.

It has been gratifying to note the interest which has been stimulated in the communities where children have returned physically restored. This interest is particularly evidenced by the number of new applications for care coming from these localities. The rate at which previously unknown cases are being referred is increasing month by month.

The Crippled Children's Division has the wholehearted support of the State Medical Association and much has been done by this organization in acquainting its members with the service. This understanding and interest on the part of the medical group is further evidenced by a joint undertaking between the State Medical Association and the Crippled Children's Division for a series of postgraduate courses for physicians, which will particularly emphasize the preventive aspects of the program. Similarly, during the convention of the State Nurses' Association, as well as during the State Conference of Social Work, demonstration clinics will be held to illustrate the various types of care a child may need after he returns home from a treatment center. Obviously, the public health nurse would seem to be the worker to carry on these activities. However, since there are organized health units in only five out of the fourteen counties, other counties having only a single county school nurse—and one having none—it has been necessary to call on the next best equipped group, the social service workers. Nor is this explanation given as an apology; for this group, organized as it is in all fourteen of the counties, has given of its best, as have the public health nurses, and both have contributed much to the program.

Great as is Arizona's interest in her handicapped children, it is doubtful whether the program could have been put into effect at this time without the assistance of the United States Children's Bureau. Much has been accomplished, but much remains to be done. Arizona is a state which has had to blast its roads through mountain ranges. It has had to build hundreds of miles of canals in order to carry its waters from natural mountain reservoirs to its desert valleys. It has had to overcome obstacles which have appeared to be insurmountable in order that its very people might survive. Such a state will not fail its handicapped children.

# Adult Hygiene

By HERBERT L. LOMBARD, M.D.
Director, Division of Adult Hygiene, Massachusetts Department of Public Health

**What should be included in the health supervision of adults? This article in simple question and answer form offers valuable suggestions for teaching materials**

QUESTION: Doctor, I read in the paper the other day that public health measures during the past fifty years had caused the average age at time of death of the population to increase twenty years. Is this true?

ANSWER: There has been an increase in the average age at time of death of all individuals. This has been caused largely by saving the lives of babies and little children who formerly died of communicable diseases, digestive disturbances, and tuberculosis. This has caused the average age of time of death to increase. There has been no increase, however, among the group over fifty. They are living no longer than they did fifty years ago.

QUESTION: Will public health work change the situation?

ANSWER: There is a possibility that the expectancy of life over fifty may be slightly increased but it is extremely improbable that many years will be added to the lives of members of the over-fifty group. Public health activities are directed to increasing the *health span* rather than the life span. At the present time a large number of individuals in the over-fifty age group are sick for years prior to death. If we can cut down the length of illness so that they live as well individuals until a short time before death we shall have accomplished much. That is the purpose of the Division of Adult Hygiene.

Reprinted from *The Commonhealth*, Massachusetts Department of Public Health, Oct.-Nov.-Dec., 1935.

QUESTION: How do you know that people are sick for long periods prior to death?

ANSWER: During the past three years we have been conducting an extensive survey in Massachusetts and have records of nearly 50,000 individuals over the age of forty. We find that more than one fourth of all men and women over forty are sick with some chronic disease and many of them had this complaint for years.

QUESTION: What are the principal sicknesses that you found in the survey?

ANSWER: About one third of the sick individuals complained of rheumatism, about one sixth of heart disease, and about one twelfth of arteriosclerosis or hardening of the arteries. Cancer, which kills a large percentage of individuals over forty, does not form a large percentage of sickness as it is a disease of relatively short duration while many of these other diseases incapacitate for many years.

QUESTION: Have you any idea of the money loss from chronic sickness in Massachusetts?

ANSWER: We estimate that about $42,000,000 each year is lost in wages. If we add to this the cost of medical care and nursing care, the figure is much greater. Eight million dollars per year is lost in wages by individuals with rheumatism.

QUESTION: What are you doing to prevent these diseases?

ANSWER: At the present time we are studying the reasons for the cause of

many of these diseases. We know the cause of some. Others we do not and for the next few years a great part of our work will be in trying to find the reasons why some people have chronic disease and others do not. In this study we are using the material which we collected in our three-years' survey.

QUESTION: Must we wait until your studies are completed before anything can be done for this group?

ANSWER: By no means. Our present knowledge, if applied to the populace at large, will accomplish much. Probably we will not be able to prevent the occurrence of some of these diseases, but we can at least delay it and arrest the condition if it has already begun. Take cancer, for example. We are unable to prevent the occurrence of this disease in many individuals; but if an individual has an early symptom, goes to the physician, and has the lesion treated, we can promise a cure in many cases. With diabetes, an individual who adheres to the advice of his physician can live as long as if he did not have the disease. Two thirds of the cases of rheumatism can be either arrested or cured. If we wait until the disease is no longer in the early stage the situation is entirely different. Chronic disease is, by and large, a race against time.

QUESTION: What do you consider hygienic living, doctor?

ANSWER: Hygienic living includes the proper food, proper exercise, and proper relaxation.

QUESTION: I am particularly anxious for advice about diet. My breakfast consists of coffee and toast: for lunch I have a sandwich and coffee! and for dinner—soup, potato, meat, bread and butter, and coffee. I am not gaining any weight. Is this all right?

ANSWER: Your diet is very poor. It is not well balanced between acid and alkaline producing foods. Furthermore, certain of the vitamins are taken in far too few quantities. You need more food at breakfast, as the greater part of the work has to be done in the daytime and you need food for its accomplishment.

QUESTION: I don't quite understand what you mean by acid and alkali, doctor.

ANSWER: The meats, breads, starches, and sugars when broken up in the body form acids, while the fruits and vegetables become alkalis. You need a mixture of the acids and the alkalis in your system.

QUESTION: What about the vitamins, doctor?

ANSWER: Everyone should eat protective foods. These contain vitamins in sufficient quantity for proper body functioning. Milk, fruits, cabbage, tomatoes, lettuce, and greens are the principal foods of this class. Every individual should consume at least a pint of milk daily. Some of this may be in soup; a part of it in coffee and on cereals. In addition, at least two helpings of the other protective foods should be taken. Tomatoes and cabbage are particularly good if eaten raw. A diet without these foods is apt to greatly impair the health of the individual.

QUESTION: I do not wish to gain weight. I am afraid of overeating, doctor.

ANSWER: None of the protective foods has many calories. However, if your weight is not what it should be, with a better diet your weight may decrease. I think we are too prone to measure proper weight by yardsticks that are none too good. What is overweight in one individual is not overweight in another. The leaves on the trees vary in size, animals vary in size, all nature shows variations, and it is to be expected that individuals will vary. There are limits beyond which it is desirable not to go. If an individual is greatly overweight or greatly underweight he is more apt to develop some disease. I think the greatly underweight group is fully as apt to become sick as the greatly overweight. A change in weight is of more importance

than either over or underweight. If you have noticed a sudden change it is well to consult your physician as to the meaning of this. I am not advocating obesity but some variation from the weight-height scale should not cause worry.

QUESTION: What about tea and coffee, doctor?

ANSWER: The excessive use of either of these drinks should not be indulged in. I have known individuals who drank nine or ten cups of tea and coffee daily. This is certainly too much.

QUESTION: Does smoking harm us?

ANSWER: Again I think it is the amount of smoking rather than the fact whether or not you are a smoker. There is some evidence to believe that cancer of the mouth is more apt to occur in those who are excessive smokers than in those who are not. Everyone who smokes should have his teeth cleaned at frequent intervals by a dentist, probably at least four times a year.

QUESTION: I suppose exercise is good, doctor, yet I find I am often tired the next morning after vigorous exercise.

ANSWER: Exercise, like everything else, should be in moderation. If carried to the point where one is overtired the next day it has probably been overdone. The man of forty-five and over cannot perform the same amount of exercise that he did at the age of twenty. He should moderate his exercise based on his previous habits. The more sedentary the occupation, the more moderate should be the physical recreation as the years increase. For a man to sit at his desk during the year and then in his two-weeks' vacation to go into violent athletics is very dangerous. Running for trains when one is not in the habit of running is another form of exercise that may cause serious consequences. As we grow older we must realize that we cannot do the things we were accustomed to do in early life. Moderate exercise, however, is good.

QUESTION: What about fatigue?

ANSWER: There are different kinds of fatigue. One is caused by overexertion of the muscles and one by nervous energy. If an individual is chronically tired it indicates that something is the matter. A careful examination should be made by a physician to determine the type of fatigue. If an individual has a physique enabling him to do only an 80 percent job and he is doing a 100 percent job, fatigue is bound to occur. The physician's examination may show that his body is not functioning properly either through lack of certain glandular secretions or perhaps poisons from an infected tooth or tonsil. If the individual is below par and attempts to do more than his body will allow, fatigue is bound to occur. Then there is the other type where nervous energy is being used up. A man may be tired at the end of the day and yet be able to attend a dance, and dance every dance until midnight. That type of fatigue is nervous and that individual needs relaxation. Few of us have a sufficient amount of rest. This is one of the most important items in hygiene. An individual demanding more rest may often try to improve his body tone by more food, and as a result, an undue amount of fatness may occur. Frequently, these individuals, if given more rest, will find they require less food.

QUESTION: What other suggestions have you, doctor, regarding proper hygiene?

ANSWER: I would try to avoid tight clothing and would try to have as good posture as possible. Poor posture is often responsible for many of the discomforts of life.

QUESTION: What about cold baths?

ANSWER: Some individuals react very well to cold baths while others do not. If the bath is followed by a glow and sense of well-being, it is beneficial. If it is not, it shows that the individual should not take them throughout the year. Speaking of baths, an excessively hot bath is just as dangerous as a cold

one. I knew one individual who came near fainting in the bath-tub several times and when the temperature of the water was taken it was found to be far in excess of that which an individual should have. The ordinary warm bath should be not much warmer than the body itself.

QUESTION: I am subject to colds. What can I do about it?

ANSWER: Colds are contagious and apparently they give little immunity to subsequent ones. Different individuals, however, vary in the number of colds they have. You should keep your body in the best physical condition, and so far as possible, keep away from other persons who are coughing and sneezing. When you get a cold, go to bed if your temperature rises. Trying to work with an infection present is one of the easiest ways to bring on complications. With a cold you should be careful of drafts, wet feet, and chilling. Pneumonia often follows a cold plus exposure. Moreover, there is a greater strain on several of the vital organs during the process of a cold. Stay in bed until your temperature is normal. The same advice applies to any acute infection. We are willing to go to bed with severe infections, but with the seemingly mild ones like colds and tonsillitis, we may try to work. Such a practice is folly.

---

## OIL DROPS IN A BABY'S NOSE

Speaking of colds, especially among babies and young children, Dr. R. H. Riley, Director of the State Department of Health, cautions mothers against following the advice of neighbors or friends with regard to the use of "cures" or methods of treatment. He warns especially against the widespread use of oil drops in a baby's nose. It is a dangerous custom, he said, and has been found to have very serious after-effects. In some instances, the indiscriminate use of such drops has brought on a certain form of pneumonia that is particularly fatal to young children. Oil nose drops should never be used for young children, he added, unless that method of treatment is specifically ordered by the physician.

Here is Dr. Riley's explanation of the warning: "In a small baby the nasal passages are very short and it is quite easy for oily fluids put into the nose of such an infant to get down into the lungs. Oil is not absorbed in the nose and therefore gradually seeps downward. In the lungs the oil sets up an irritation and produces a certain variety of pneumonia. The disease develops slowly and the harm is often done before the trouble is discovered. This kind of pneumonia does not yield to the usual form of treatment. Reports from different parts of the country show that it has been responsible for many deaths. In almost every case careful inquiry has shown that oil drops had been used.

"Many manufacturers of nose drops have realized the seriousness of the situation and have printed instructions on the labels of their products not to use oil nose drops in children under two years old, unless prescribed by a physician. Most hospitals and dispensaries now make it a rule never to order such treatment for young infants. It is important, however, for mothers themselves to understand about the danger so that they will avoid using nose drops except under a doctor's orders and direction.

"The best plan for any mother to follow in order that she may safeguard her baby from avoidable sickness is to have the baby inspected at regular intervals by the family physician and to call him promptly between-times whenever symptoms of illness show themselves."

—*Press Bulletin* 692, Department of Health, State of Maryland, November 1, 1937

# A Study of Volunteer Services

By EVELYN K. DAVIS
Assistant Director, National Organization for Public Health Nursing

**How are volunteers recruited by agency? Who is responsible for placing them and how are they trained? What are some assets and liabilities of a volunteer service?**

A QUESTIONNAIRE on volunteer service was sent out by the National Organization for Public Health Nursing in February 1937, to the organizations which reported in the Yearly Review that they were using volunteers. The questionnaire went to 86 private agencies and 15 public agencies. There was no follow-up to secure answers from those who failed to reply, and the returns which came in were as follows:

| | |
|---|---|
| Number of private agencies reporting | 49 |
| Number of public agencies reporting | |
| State health departments | 3 |
| County health departments | 10 |
| Total | 62 |

It is rather difficult to make a scientific analysis of the material which came in, and the summaries which follow are not to be considered very accurate from the statistical point of view. However, the returns seem to be indicative of the way in which volunteers are being used and trained. The Executive Committee of the Board Members' Section considers that although many more jobs were reported than in the 1930 study,* the returns on the whole showed that public health nursing organizations were not doing a very good job in the development of their program for volunteers.

Mr. Charles P. Taft at a meeting of the National Conference of Social Work in May 1937, said: " . . . if you build up over a period of years real lay committees and volunteer workers, you won't need to worry about public relations. They will interpret your work for you and they will multiply your hands. They are likely to be individualists, and you can't bawl them out or order them around, and they are sometimes nuisances; but they are nevertheless a cross section of the people of the United States and you had better learn to make them your friends and helpers if you really want social work to play the part it can in healing the wounds of our machine age."**

More and more leaders—both lay and professional—in the field of social welfare have stressed in recent meetings the definite need for better and more extensive volunteer service within their agencies. They consider, as does the N.O.P.H.N., that the layman is one of our best interpreters; that one way to have knowledge of the program is to participate in the work: and that being an assistant to the professional worker and having a definite job to do increases an individual's knowledge of and interest in public health. It would seem that public health nursing organizations are losing a real opportunity if they are not making the development of volunteer service within their agencies a definite part of their programs.

*National Organization for Public Health Nursing. Volunteer Service for Public Health Nursing Organizations. THE PUBLIC HEALTH NURSE, January 1931, p.34.

**Taft, Charles P. Address on "Public Welfare and Efficiency in Government," presented at National Conference of Social Work, May 25, 1937, Indianapolis, Ind. Excerpt published in *News Bulletin*, Community Chests and Councils, Inc., June 1937, p.20.

The study did not show whether the weaknesses are due to a lack of interest; to lack of time for the training and supervising of workers—since it does take the time of at least one member of the professional staff; to a feeling that a layman is not able or qualified to carry on work which a professional person has been doing; or to a definite feeling that the volunteer has no place in the service. If we agree on the premise that volunteer service is important, it seems that the only way we can prove its effectiveness is to spend time in developing it within the agency. The recently revised *Board Members' Manual* of the N.O.P.H.N. has a special chapter on developing a volunteer program, giving definite suggestions as to the set-up of the program within an agency.* And in view of the findings of this recent study on volunteer service it is most timely to have the suggestions published at this moment.

### STUDY ON VOLUNTEERS

A. Recruiting of volunteers

1. Methods used to recruit volunteer workers:

| | Agencies |
|---|---|
| Personal appeal to groups (talks) | 48 |
| People known to association approached by nurses and board members | 5 |
| Use of volunteer bureau, council of social agencies | 3 |
| Offer of services by volunteers | 2 |
| Appeal to people in area where nurses are working | 2 |
| Publicity about needs, such as in local newspapers | 2 |
| No special plan of publicity | 2 |
| Written requests to several groups | 1 |
| Volunteers recommended by volunteers | 1 |

2. From what groups do they come?

| | |
|---|---|
| Junior League | 25 |
| Church | 15 |
| Parent-teacher association | 10 |
| Girl Scouts | 7 |
| Visiting nurse association board | 5 |
| Volunteer bureau | 3 |
| Council of Jewish women | 3 |
| Retired nurses | 3 |
| Teachers | 3 |
| University students | 2 |
| Grange | 2 |
| Business school | 2 |
| College women's club | 2 |
| Former patients | 1 |
| Boy Scouts | 1 |
| Automobile dealers | 1 |
| Friends of board members | 1 |
| American Red Cross | 1 |

B. Placing of volunteers:

1. Who is responsible for placing volunteers?

| | |
|---|---|
| Director of nurses | 19 |
| No policy | 11 |
| Junior League placement chairman | 9 |
| Chairman of volunteer committee | 8 |
| Director of nurses and chairman of volunteer committee | 8 |
| Board member | 6 |
| Volunteer bureau of council of social agencies | 3 |
| School for clerical workers | 2 |
| Mental hygiene supervisor | 1 |
| Educational director | 1 |
| Clerk in charge of office work | 1 |
| Chairman of committee from which volunteer comes | 1 |

C. Training of volunteers:

| | |
|---|---|
| Number of agencies reporting training courses given | 10 |
| Number of agencies reporting no special training | 12 |
| Number of agencies not reporting at all | 13 |

1. What length are the training courses?

The 10 courses which were reported varied in length from 1½ hours to 10 weeks.

2. Who gives the courses?

These 10 courses were reported as given by:

| | |
|---|---|
| The nurses in the agency | 6 |
| The council of social agencies | 2 |
| The director and the nurses | 1 |
| The education committee and the Junior League | 1 |

3. What type of training is used, other than courses?

| | |
|---|---|
| Training on the job | 11 |
| Training as needed for specific jobs | 10 |

*National Organization for Public Health Nursing. Board Members' Manual. The Macmillan Company, New York, second edition revised, 1937, Chapter XI.

| | |
|---|---|
| Observation and supervised experience | 5 |
| Preliminary conferences | 4 |
| Observation | 3 |
| Demonstration | 3 |
| Typewritten rules or booklet of instructions | 2 |
| Observation and demonstration combined | 1 |
| Training in volunteer bureaus outside of the agency | 2 |

D. Further training of volunteers:

1. Do agencies have regular group meetings of volunteers?

| | |
|---|---|
| Agencies reporting regular meetings | 16 |
| Agencies reporting an occasional meeting | 3 |

2. Who conducts group meetings?

| | |
|---|---|
| Chairman of volunteer committee | 12 |
| Nurse director | 3 |
| Nurse director and chairman of volunteer committee | 2 |
| No leader reported by agency | 2 |

3. Are volunteers ever invited to meetings?

| | |
|---|---|
| Board meetings (occasionally) | 25 |
| Staff meetings | 15 |
| Annual meeting only | 3 |

E. Regularity of attendance of volunteers:

1. Schedule of attendance:

*a.* Is there a regular schedule of attendance?

Yes—54 agencies; no—6; no answer—7

*b.* Do the volunteers adhere to it?

Yes—46 agencies; no—1; usually—9; no answer—11

*c.* Are you notified when they cannot come?

Yes—30 agencies; no—2; usually—15; no answer—12

| | |
|---|---|
| F. Total number of volunteers reported working | 1872 |
| Agencies reporting no count of their volunteers | 24 |

G. Reasons for leaving the volunteer staff:

| | |
|---|---|
| No report | 34 |
| Departure from city | 20 |
| Pregnancy | 11 |
| Illness | 9 |
| Other interests | 8 |
| Paid job | 5 |
| Tired of work | 5 |
| Left to become board members | 2 |

H. Value of volunteer service:

The answers to the question asking for an estimate of the value of the volunteer service is impossible to analyze statistically. The service was reported as equal to one full-time staff nurse, one full-time office worker, $12,000 a year, $58.50 a month, and other equivalents.

1. What do you consider are the assets in using the service of volunteers?

| | |
|---|---|
| Interpretation and publicity | 48 |
| Saving of nurses' time | 23 |
| Training for board membership | 9 |
| Promotion of public health | 6 |
| Provision of service which organization could not otherwise give | 5 |
| Stimulation to staff | 4 |
| Keeps nurses informed as to needs of community | 2 |
| Makes large financial contribution | 1 |
| Stimulates wider interest in all community development | 1 |

2. What are the liabilities and problems?

| | |
|---|---|
| Volunteers do not always take work seriously | 9 |
| Take too much time of professional worker | 7 |
| No problems with volunteer workers | 7 |
| Volunteers don't always give ethical advice | 5 |
| Irregular in attendance | 8 |
| Too sympathetic | 4 |
| Too difficult a problem to keep volunteer busy | 3 |
| Difficulty in finding good volunteers | 3 |
| Not as fast workers as professional workers | 2 |
| Give incorrect interpretation of service of agency | 3 |
| Don't always like their jobs | 2 |
| Volunteers let other things interfere with work | 2 |
| Not always as capable as they think they are | 1 |
| Volunteer fears injury or infection | 1 |

I. Interesting new jobs reported:

Making homemade toys for clinics and demonstrating to mothers how to make them.

Setting up complete health demonstration materials for health conferences and serving tea at the conferences.

Operating a circulating library for shut-ins.

Cataloguing of library.

Keeping employment statistics every month.

Making a survey of all children under ten years of age—diseases, operations, and immunizations—and preparing a file.

Making a detailed study of maternity work from dismissed records.

Organization of a colored nursing council so that they might meet their own problems.

Teaching mothers to make their own layettes.

Making of pen and ink sketches for annual reports.

Writing of stories for newspaper articles, based on field visits of nurse.

A volunteer with special nursery school experience is given charge of preschool children at play in a child welfare conference and is to interpret to the mother the behavior of children.

A volunteer is made responsible for improvements in rural school sanitation.

A volunteer trained in psychiatry attends neurological clinic held for children with birth injuries, and interprets the doctor's findings to mothers in the homes.

Putting on a puppet show.

A history of public health nursing was worked out by a group, dressing dolls in period costumes.

#### ASSETS AND LIABILITIES

An analysis of the assets and liabilities reported certainly shows that the assets greatly exceed the liabilities. Forty-eight out of the 62 agencies consider that volunteers are a great asset both from a publicity and interpretive angle. The discouraging thing comes in the listing of liabilities, since the liabilities which are reported show that the agencies are not doing a good job with the selection and training of the volunteer. Certainly the volunteer should not give unethical advice, should take the job seriously, should be regular and interested—if care has been taken in selecting her in the beginning, placing her in a job in which she is interested and which she is able to do, and giving her definite training.

Only 10 agencies out of the 62 reported definite courses. With organizations such as the Junior League, parent-teacher groups, and women's clubs emphasizing study courses for training the layman, it seems important for public health nursing agencies to train their volunteers as well.

Volunteer bureaus under councils of social agencies are growing quite rapidly in the United States. In fact, at the present time there are 25 in existence; but only three of the agencies reported using volunteer bureaus. Comments have come from some of the volunteer placement executives and chairmen of Junior Leagues, that although the work in a public health nursing agency is of tremendous interest to the volunteers, they do not get good training or supervision when they work in the agency.

#### SOURCES OF MATERIAL

Recently several very good articles from national agencies have appeared in current magazines and in pamphlet form, which will be of value to local public health nursing organizations in developing their volunteer programs. For example, an article on "Training and Using the Volunteer Interpreter," appeared in the September 1937 issue of the *News Bulletin* of the Social Work Publicity Council. This organization, which has its office at 130 East 22 Street, New York, N. Y., is a membership organization whose *News Bulletin* is published eight times a year. Single copies of the bulletin sell for 30 cents each.

A pamphlet entitled, "The Program Volunteer in the Y.W.C.A.," by Jeanette Dutchess, has been published by the National Board of the Young Women's Christian Association. This is prepared by the Womans Press, 600 Lexington Avenue, New York, N. Y., and sells for 25 cents a copy. In the pamphlet is suggested the possibility of having the

volunteer make a self-evaluation of her own. An outline for this self-evaluation is as follows:

Report of Volunteer
to
Young Women's Christian Association

of .....

for .....
(period of time)

What satisfaction have you found in your association experience?
What have been for you its major difficulties?
Would you like to go on with the type of association work you have been doing?
If not, what would you rather do?
Do you have additional remarks or suggestions? If so, what?

Signed .....

Address .....

Date.....

A resumé of a talk on "The Volunteer as Interpreter," by Miss Virginia Howlett, secretary of the Junior League welfare department, appeared in the September 1937 issue of the *Junior League Magazine*, published by the Association of Junior Leagues of America, Inc., The Waldorf-Astoria, New York, N. Y. This talk was given at the National Conference of Social Work in Indianapolis in May.

In order to assist local organizations in developing training programs for their volunteer workers and in order to answer the many requests for outlines of training programs, a course has been prepared by the N.O.P.H.N. and was published in the December 1937 issue of PUBLIC HEALTH NURSING under the title of "A Training Course for Volunteers in the Public Health Nursing Field."

## GUIDE POST FOR BOARD MEMBERS

A rural county health unit meets its problems by building sound relationships within and outside of the organization and utilizing all of its community resources—both official and non-official. Page 3.

Some recommendations which may be used as a guide by agencies taking nursing students for affiliation are offered by the N.O.P.H.N. Education Committee on page 15.

The opinions of agencies regarding the values and liabilities of volunteer service are included in a report of a study. Page 38.

A lay person answers the question, "What benefits can my community derive from the N.O.P.H.N.?" in the prize essay contest for life memberships. Page 47.

A great southwestern state overcomes tremendous physical difficulties and works out a program for its crippled children. It is described on page 31.

The values and strengths which come to every community through partnership in a national organization are succinctly described by the N.O.P.H.N. Membership Chairman. Page 1.

To give the best service to the community, a nurse must be reasonably comfortable and happy in her living conditions and social life. A rural nurse makes an interesting little study of "How Rural Nurses Live," in her part of the country. Page 19.

We have materially reduced infant mortality and improved the health of childhood. What can be done to improve the health of adults? Page 34.

Does your community have nursing service planned upon the basis of its needs—without gaps or overlapping? Suggestions for developing planned community nursing service through nursing councils are given on page 26.

# How Would You Answer This?

An obstetric reference library was awarded by the Maternity Center Association to the nurse who most satisfactorily answered the question given below, which was published in the May number (page 321). As announced in December, the writer of the prize-winning answer was Elizabeth McLaughlin, who since submitting her answer has become a member of the staff of the Child Welfare and Community Health Association, New Orleans, Louisiana.

The prize-winning answer, which appears below, was the best paper submitted in the contest. It contains, however, some flaws. We are publishing the answer as submitted, in order to stimulate further discussion on this important subject of program planning. Your critical analysis is invited.

### THE QUESTION

**If you were responsible for directing the work of 14 visiting nurses in the community described below, how much time would you devote to maternity service and what would that service include? Tell how you arrived at your decision.**

**The community is urban and has a population of 30,000. There is no real poverty. There were 500 births last year, 300 in hospitals and 200 at home. There are 3150 preschool children and 4500 school children. Last year it required 11,000 nursing visits to give bedside care to the sick in the homes, exclusive of visits to obstetric patients. There is no other community nursing service except that provided by private duty nurses.**

### THE ANSWER

*(Your comments on this answer are invited. See page 45, "How would you answer these?")*

For the community described and on the basis of the figures as given, a maternity service might be arranged on the following plan:

The fourteen visiting nurses are divided into two groups. Group I is composed of eleven nurses to perform the morbidity, preschool and school hygiene, and antepartum service, leaving three nurses in Group II on full-time delivery and postpartum service. In order to afford varied experience to all the staff nurses, they may serve on both services in rotation.

This arrangement would allow 11/14 of the total time on morbidity, preschool and school hygiene, and antepartum work. A detailed division of the work of this group shows the full time of approximately six nurses to be spent on morbidity; of three on preschool and school hygiene, and of two on antepartum work. The service is, however, generalized within the group, with one nurse performing all services necessary in one home.

By adding the time of the two nurses allowed for antepartum work in Group I to those of Group II, 5/14 of the service is given to maternity work.

The work of Group II is arranged as follows: A 24-hour delivery service with the nurses on call in rotation leaves at least one nurse free to do the necessary postpartum work. If a nurse is called out at night, she is allowed equivalent time off duty the next day. These nurses work no more than eight hours a day, although their hours, by necessity, are not as regular as those on the other services. In slack periods these three nurses may assist with antepartum work, and likewise, those of Group I may be called in to assist Group II when the occasion demands, at the discretion of the nursing supervisor. The nurses waiting on delivery call assist in the maternity clinics with examinations, mothers' classes, and demonstrations, and keep up supplies and records.

The antepartum service includes monthly visits to the patients, spaced preferably between clinic visits. Late in pregnancy it may be necessary to make more frequent visits. At each visit, the nurse takes the blood pressure, tests the

urine for albumen, and checks other factors such as varicosities, vaginal discharge, headache, dizziness, care of the breasts, and constipation. She advises the patient concerning diet, rest, and exercise, and sees that the patient keeps her clinic appointments. She instructs the mother regarding supplies for the baby and preparations in case of a home delivery. The manifold opportunities here afforded the nurse for teaching hygiene in the home are not overlooked, and she attempts to gain the interest and coöperation of the husband in the care of the mother and preparations for the baby. The nurse investigates the social conditions of the family and refers them to the proper social agencies for necessary help or guidance. The patient is instructed as to means of getting in touch with the doctor and nurse when labor begins or how to reach the hospital for delivery.

The postpartum service includes seven visits besides the delivery. On the first two days the nurse will give the patient her complete bath. On the third day postpartum the mother may often take her own bath while the nurse is giving the baby-bath. On the fifth day the nurse shows the mother—or if she is not able, someone in the home—how to oil the baby, and how to give the perineal bath. She asks the patient to have certain supplies ready for the seventh day for the nurse to demonstrate the baby's bath. The nurse does not return on the sixth and eighth days, but on the ninth day she returns for the mother to demonstrate to her the baby's water bath. During these visits the nurse gives instructions as to care of both mother and baby, demonstrates the preparation of the formula if one is necessary, and teaches general hygiene in the home. At least three (and better five) follow-up visits are made, spaced at ten-day or weekly intervals, to check on the baby's weight and feeding schedule and the condition of the mother, to deliver the birth certificate, and to see that the mother returns to her doctor or clinic for postpartum examination. In addition, guidance is given toward continued supervision of the baby through a private physician or clinic.

This table shows approximate calculation for the plan:

| | Service | Total no. of nurses full time | | Total no. of visits per year | Total no. of visits per month | Total no. of visits per day* | | Average no. of visits by 1 nurse in 1 day |
|---|---|---|---|---|---|---|---|---|
| Group I | Preschool and school | 3 | 11 | 11,000 | 916 | 36.6 | 43.6 | 3.9** |
| | Morbidity | 6 | | | | | | |
| | Maternity | | | | | | | |
| | *a.* Antepartum | 2 | | 2100† (300 pts x 7) | 175 | 7 | | |
| Group II | *b.* Delivery | 2 | 3 | 200 | 16.6 | 0.66 | | 0.33 |
| | *c.* Postnatal | 1 | | 2000†† (200 x 10) | 166 | 6.6 | | 6.6 |

*The average of twenty-five working days per month is used, to allow for holidays and the unequal number of days in some months.

**This figure of 3.9 visits a day for each nurse is not a full load, but no calculations are advanced for the preschool and school hygiene service, which may be cared for in the time left over, as that time allows.

†This figure of 2100 antepartum visits includes visits to the 200 patients delivered at home and to 100 of the 300 patients delivered in the hospital. Of course, some of the 200 patients delivered at home may not use the nursing service. This is, perhaps, a maximum figure. An average of seven antepartum visits is estimated since some patients will not register in the early months of pregnancy.

††This figure allows for 10 visits—seven postpartum nursing visits and three follow-up visits—to the 200 patients delivered on the service.

## HOW WOULD YOU ANSWER THESE?

1. Starting with the number of visits per year, as given by the author, what distribution of nurses do you arrive at—assuming the average number of visits per nurse per year to be 2200?* Compare this with the author's distribution.

2. On the basis of the total number of visits per day and the number of nurses for each service, as shown in the table, how many visits *per nurse* per day do you get for *each service?* From the table, is it possible to compare each of your figures with the author's results? What service is not provided for in this calculation?

3. Using the figures which you get in 2, how many visits per nurse per day do you get for the morbidity and antepartum services combined? Compare this with the author's result (3.9). Would the nurse have time left over for additional visits in other services.**

4. How many visits per nurse per day do you get for delivery and postnatal services combined? (Multiply the number of delivery visits arrived at in question 2 above, by eight, before adding to the postnatal visits.*) Could the nurse make additional visits in other services?**

5. Would you conclude that the author of the prize-winning article apparently arrived at her distribution of nurses:

*a.* By first analyzing the volume of service required on the basis of facts given, and then estimating the number of nurses required to meet those needs according to generally accepted standards? (See *Community Health Organization* by Ira V. Hiscock, page 155)—*or*

*b.* By first assuming a certain distribution of nurses between services and then dividing the volume of expected service between the nurses?

6. Now that you have read and analyzed the prize-winning answer to the question on the allocation of time to maternity service in the community described on page 43, how would *you* answer the question?

*For the delivery service, assume that the 200 delivery visits are equivalent to 1600 usual visits. (See "The Delivery Visit," PUBLIC HEALTH NURSING, April 1937, page 242.

**An average of 8 to 10 visits per day for each nurse may be assumed.

---

## CONFERENCE ON BETTER CARE FOR MOTHERS AND BABIES

A Conference on Better Care for Mothers and Babies is to be held in Washington, D. C., January 17 and 18, 1938, under the auspices of the U. S. Children's Bureau, at the request of various professional groups and national organizations interested in this subject.

Early in 1937 the Special Committee on Maternal Welfare, appointed to advise the Children's Bureau in its administration of the maternal and child health services, met to consider problems in this field. The Committee unanimously agreed that extension of services to permit care of mothers at childbirth is an outstanding necessity. Recommendations to this effect were unanimously endorsed by the committees advisory to the Children's Bureau. Similar resolutions have been drawn up by a joint committee of the State and Territorial Health Officers and the State and Provincial Health Authorities of North America, by the American Public Health Association, and by the American Legion. A recent newspaper poll of public opinion has indicated that 81 percent of the American people favor

the use of public funds to provide care at childbirth to needy mothers.

Briefly the proposals for an expanded program for maternal care as recommended by the advisory committees include:

1. Care of the mother in the home by a qualified physician aided by a public health nurse before, during, and after confinement.
2. Delivery care in approved or acceptable hospitals equipped to handle emergency or complicated cases for any woman who needs such care because of social, medical, or economic reasons, or inaccessibility of skilled care in her own home.
3. Consultation service by obstetricians and pediatricians to aid general practitioners in their care of mothers and infants.
4. A program of postgraduate education to teach urban and rural physicians and nurses the fundamental principles of complete maternal and infant care.

The necessity of coöperation with national, state, and local medical societies in working out any plan was particularly emphasized by the committees in presenting these proposals. The maternal and child health services now being developed under the Social Security Act have stimulated interest in prenatal and postnatal care. No medical care at the time of delivery is being provided from maternal and child health funds. Yet we know that only by competent care at the time of delivery can the lives of many mothers be saved.

In October 1937 Katharine F. Lenroot, Chief of the Children's Bureau, called a small conference of representatives of medical, professional, and lay groups to consider the necessary next steps. It was the sense of this conference that a larger conference should be called in January at which time the needs and the measures to meet these needs could be discussed before a larger group.

**The triplets' day begins**

# What Benefits Can My Community Derive from the N.O.P.H.N.?

***Life Membership Prize Essay for Laymen***

**This is the prize-winning article which won its author a life membership in the National Organization for Public Health Nursing for the best essay written on the subject by a lay person. The prize-winning essay written by a nurse will be published in February**

LEGEND tells us that during the days of the stagecoach, one of the drivers in this Minnesota territory was an artist in handling his long blacksnake whip. So skillful was he that he could not only flick the flies off the backs of his horses without even tickling the animals; he could cast the end of the whip around the choicest flowers along the way, draw them in, and present each lady with a bouquet at the end of the journey. A passenger one day asked the driver that he snare for him a rather peculiar looking object hanging from one of the tree branches. The reply was this, "Sir, if that were an individual member I would be most pleased to oblige; but that is an organization—it's a hornets' nest."

There we have the whole story of the National Organization for Public Health Nursing. It, too, is an *organization;* a large corporate group; many *individual members* joined together for the advancement of a profession and the more successful rendering of service to the public.

In our present-day system of civilization, we see the example of group organization on every hand. We have left the stage of individual production and every necessity of living is supplied to us through mass-production methods. No one can deny the superiority of products, at less cost, that such methods offer. What is true in the economic field is also true in the humanitarian field. Our American Red Cross, National Tuberculosis Association, American Society for the Control of Cancer, and many others have made possible work which no small group could have accomplished alone. The criticism of a large organization is sometimes that it becomes so far reaching in its endeavors that it sometimes fails to return anything to the small community or group of individuals for whose benefit it was originally intended. What are some of the benefits my community derives from this organization, national though its scope may be?

Through its prestige, which leaders of high caliber have built, it has been in a position to suggest and obtain the raising of standards of training for those going into public health work. Universities and colleges which are offering special work in the field have had an opportunity to find out what is needed and wanted in these courses, thereby graduating public health nurses who are specifically trained for the job that they will have to do. The better trained the nurse who goes into any community, the more the community benefits.

The National Organization, through its research and publicity departments, has awakened many communities to their own needs. How often has a local public health nurse been striving to accomplish something in her community, only to find a deaf ear turned to her suggestions; but finds that when she can

For the announcements regarding this contest, see PUBLIC HEALTH NURSING, April 1937, p. 224, and December 1937, p. 723.

present the same idea from a national, authoritative source it is accepted with favor. Because of its national standing, the organization can arrange meetings and conferences to which it attracts the leaders in the lay, medical, and nursing fields. To convince this group of people of the aims, objectives, and problems of the field of public health is to win half the battle for the carrying out of a more successful program in small as well as large communities.

Perhaps the greatest return to a community is through the individual nurse or group of nurses who are employed in the field of public health in any community. Health is such a little-prized gift until it is taken away; and then how dearly we pay to regain it. But what a task it is for the public health nurse to sell us a preventive medicine program as an ounce of prevention. What a task it is to sell an immunization campaign to a community that has not had an epidemic in recent years. What a job to sell a well-baby service—the average parent feels that when the child becomes ill is the only time medical care is necessary. What a task to instruct the average American home in the meaning of isolation and proper care in communicable diseases. These and many other things are just a part of the job of the public health nurse. Small wonder, then, that the large part of the benefit that the community derives from the National Organization for Public Health Nursing is the fact that something serves to keep the courage, ideals, and morale of the workers in the field up to that point of inspiration which makes it possible to go on in spite of handicaps.

Indirectly, every community employing a public health nurse benefits from the publication of the magazine, PUBLIC HEALTH NURSING. Through this magazine are presented the most vital happenings in the field of public health. These include new techniques, new social and economic influences, and new experiments from the entire country which may be applicable to the nurse in a similar situation in any small or large community. As the nurse puts into practice these bits of information and new developments, the community profits in proportion. It may well be imagined that the National Organization is in an excellent position to help solve problems of specific difficulties—of which there are many in a field as new as that of public health nursing.

I feel toward the National Organization for Public Health Nursing the same as the stagecoach driver must have felt toward the hornets' nest—a great admiration for its ability to do things in a way that demands respect and consideration.

NORMA A. JOHANNIS
*Winona, Minnesota*

## THE AMERICAN JOURNAL OF NURSING FOR JANUARY

# A LESSON DRAMATIZED

This group education project for student nurses offers suggestions for a staff educational program, or for classes in home nursing, child care, or first aid. The principal value lies in allowing the group to work out the project themselves, which gives them the opportunity to consider all of the factors involved in the problems they are studying.

Teaching by project or by the project method means the process of educating by application on the part of the pupils of the truths being taught.

The dramatization of the care of a diabetic child is an example of a "drama project." It could be carried out along the following lines, all parts acted by student nurses:

A child, whom we shall call Mary, is seated at a table reading a book. Her mother appears with a bowl of oatmeal and a glass of orange juice. She asks Mary if she has taken her insulin. The child replies that she took it twenty minutes ago. When her mother tells her to eat her breakfast she exclaims over the fact that she has such a meagre one, and they repeat the doctor's orders concerning amounts of cream and sugar.

The mother, having household duties to attend to, leaves the room and the child continues to read the book. She does not touch her breakfast and gradually the book falls from her hands and she slumps down in her chair. The mother returns to find her thus, feels her skin, notes that it is moist, and exclaiming about insulin shock as she discovers the untouched breakfast, forces the child to drink the orange juice. Mary slowly responds and her mother helps her to a couch. At this time there is a knock on the door and a district nurse is admitted. They go over the situation together and the nurse stresses the relation of food to insulin, and the importance of strict supervision for the intelligent care of a child who obviously is not able to cope with the disease herself.

(This demonstrates to the students something of what happens to that advice they hurriedly give to patients as they are about to be discharged, and the added difficulties where children are concerned.)

By this time Mary has recovered. The nurse questions her about exercise. The mother states that Mary does not go out to play as she has a sore foot.

An examination is made, and Mary is found to have a blister, caused by improper shoes. The shoe problem is discussed; then the nurse demonstrates a foot-soak and the application of a sterile dressing. She also demonstrates lanolin massage for improving the condition of the skin, the use of lamb's wool to prevent friction, and exercises to improve the tone of the circulation.

Afterwards she has the mother repeat all the steps to be sure that she can carry out the details properly. The mother then asks a few questions. What kind of stockings shall Mary wear? How shall her nails be cut? These the nurse answers appropriately, suggesting a clean pair of white stockings every day, the nails to be cut straight across to lessen the danger of cutting the skin. She also explains in detail what happens to the circulation of the extremities in diabetes.

The nurse does not feel sure that either mother or patient is carrying out the instructions received at the hospital, so she has Mary demonstrate for her the testing of her urine and the giving of insulin, emphasizing again the relation of food to insulin and the underlying principle of an accurate urinalysis. The urinalysis Mary does quite successfully. When she demonstrates the preparation of her insulin, she drops the needle on the floor and is about to wipe it off on her sleeve and proceed. The nurse explains the purpose of boiling the needle, and Mary assures her that she will be more careful in future.

The mother tells of Mary's leg being sore from the injections. It is apparent that she is using the same site of injection each time. The nurse outlines a

plan for future injections—one leg one time, one the next, and using a different spot each time, thereby allowing at least two weeks before an area will be used again. These points were brought out purposely to aid the student in future instruction of patients.

There is a little more conversation and the project is open for class discussion.

—Reprinted in part from "The Project Method" by Dorothea S. Yens, R.N., *Irish Nursing and Hospital World,* May 1936

## STOP, LOOK, AND LISTEN!

The automobile—as a means of transportation—is necessary today for most public health nursing agencies. Actively engaged in public safety and perhaps particularly in the prevention of automobile accidents, public health nurses give strict observance to safe and courteous driving practices. Rules of the road and adherence to local regulations are a means to safety.

*The Metropolitan Life Insurance Company* lists the following driving requirements in addition to professional ones for eligibility to its nursing staff: A nurse must have had at least six months' driving experience and must hold a driver's license if one is required legally. A new nurse is not permitted to drive a car on company business until she has passed the company's motor vehicle driving examination and received the company's authorization to drive.

Examination requirements include an actual road test under traffic conditions and a written test regarding safe operating practices and rules of the road. If the nurse fails to pass the examination during her training period she has not qualified for appointment.

The company recommends subsequent driving experience and states: A nurse who has successfully passed the company's motor vehicle driving examination is expected to continue to operate her car in the safe manner in which her examination proves she is capable.

Studying the most common errors listed below, which were noted during nurses' road tests, will help to correct habits indicating improper use of a car.

### COMMON DRIVING ERRORS

*Starting*

Failure to look around. No hand signal. Unnecessarily fast or jerky start. Shifting gears in noisy or uncertain manner.

*Turning*

Improper hand signal. Failure to place car in proper position before making turn. Wide turn. Close turn.

*Passing*

Failure to wait for a clear distance ahead. Horn not used when needed. Pulling out of line without observing following traffic or giving hand signal. Cutting in ahead of the overtaken vehicle too quickly. Uncertainty (starting to pass and changing mind).

*Parking*

Too far from curb. Bumping other cars. Climbing curb. Making too many stops and starts. Failure to set brake before leaving car.

*Backing*

Failure to look behind or use mirror. Steering uncertain.

*Hills*

Improper shifting of gears going uphill. Rolling back when starting uphill. Coasting downhill in neutral.

*Traffic*

Slowing down too quickly. Following other cars too closely. Tendency to lag and then catch up with traffic. Failure to slow down before reaching an intersection or curve. Failure to keep in proper lane. Weaving in and out of traffic. Riding clutch.

*Inattentive*

Looking down when shifting gears. Turning head when talking. Using rear observation mirror too long at one time. Failure to observe other traffic at intersections.

*Traffic Regulations*

Failure to obey traffic lights, warning or stop signs. Starting before complete change of traffic signal.

*Right of Way*

Failure to yield right of way when prudent. Inconsiderate of pedestrians. Failure to anticipate probable action of other drivers.

# NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

### FROM NATIONAL TO NATIONAL

On February 1, Eleanor Weed Mumford, who has been for two years an assistant director on the N.O.P.H.N. staff, will resign to accept the position of Associate for Nursing Activities on the staff of the National Society for the Prevention of Blindness. The only reconciling feature in this change, from the N.O.P.H.N. point of view, is the fact that Miss Mumford will not be going far away—indeed, only up one flight of stairs to the "N.S.P.B." office. Miss Mumford succeeds Mrs. Francia Baird Crocker. Mrs. Crocker was married in the Fall and is now Mrs. Francis Carr. The N.O.P.H.N.'s best wishes go with Miss Mumford and also our hope—which we believe every member would like to echo—that this new opportunity for national service will bring her into closer relationship with the hundreds of public health nurses with whom she has corresponded while with us. Miss Mumford promises to return for N.O.P.H.N. staff meetings and we have a hunch it will be many a long day before we learn to think of her as an ex-staff member!

### WITH THE STAFF

Dorothy Deming and Purcelle Peck attended the Silver Anniversary dinner of the Survey Associates at the Hotel Biltmore, New York City, on December 2.

Dorothy Deming made two short trips to Washington, D. C., in December. On the 6th, she attended the meeting of the National Committee on Red Cross Nursing Service at the American Red Cross Headquarters. She returned again on December 11 and 12 to attend a meeting of the Steering Committee for the Conference on Better Care of Mothers and Babies to be held in Washington in January, and also to participate in a panel discussion on medical care at the annual conference of the American Public Welfare Association. She spent December 7 and 8 in Philadelphia attending a conference of private agency executives at the Visiting Nurse Society offices. A beautiful Silver Jubilee tea at the Art Alliance was arranged by the public health nurses in Philadelphia at this time.

Ruth Houlton spent December 3 in Bethlehem, Penna., in order to complete the survey she is making of the visiting nurse services in that city. On December 9, she spoke at a dinner given by the industrial nurses of the Rhode Island S.O.P.H.N. in Providence.

Evelyn Davis also attended the annual meeting of the American Public Welfare Association in Washington, D. C., on December 10 and 11. She participated in the discussion of the special session for board members.

Mrs. Anna J. Miller has been giving some assistance on records and statistics to nearby visiting nurse associations. She visited the Visiting Nurse Association of Stamford, Conn., on December 8, the Visiting Nurse Association of the Oranges and Maplewood, N. J., on December 9, and the District Nursing Association of Lawrence, Long Island, N. Y., on December 13.

### JOANNA JOHNSON VISITS HEADQUARTERS

Joanna Johnson, Supervisor, Industrial Nursing Department of the Employers Mutuals of Wausau, Wisconsin, and Vice-chairman of the Industrial Nursing Section of the N.O.P.H.N., spent two weeks in the N.O.P.H.N. office during December in consultation with the staff on industrial nursing.

While in the East, Miss Johnson attended the Fall meeting of the Rhode Island State Organization for Public Health Nursing and spoke on industrial nursing. She also visited various insurance companies, medical departments of industries, and directors of public health nursing courses.

The N.O.P.H.N. staff realize fully the importance of close contact with various fields of public health nursing. Hence, they grasped with eagerness this opportunity made possible through the gift of an old board member and the generosity of Employers Mutuals to secure this consultant service from a leading nurse in the industrial field.

A small dinner was arranged by the N.O.P.H.N. in order that representative industrial nurses of New York and vicinity might have an opportunity to meet Miss Johnson. It was held at the Town Hall Club, New York City, on December 16, and was attended by six members of the N.O.P.H.N. staff and eleven industrial nurses. Miss Johnson made a report of the activities of the Nursing Section of the National Safety Council during the past year. Various problems of industrial health were discussed, particularly the interpretation of health service to management.

### JANUARY MEETINGS

The annual meeting of the Board of Directors of the N.O.P.H.N. will take place in New York City, January 26 and 27. It will be preceded by a meeting of the Finance Committee and followed by a meeting of the Joint Boards of the N.O.P.H.N., the American Nurses' Association, and the National League of Nursing Education. A dinner meeting of the Magazine Committee will be held on the evening of January 26.

On Friday, January 28, the presidents of the S.O.P.H.N.—who are ex-officio members of the Board of Directors and who have been invited to attend the Board meetings—will hold a conference on state programs and N.O.P.H.N. relationships.

## JOINT VOCATIONAL SERVICE

announces November 1937 placements and assisted placements, as follows:

### PLACEMENTS

Maud Adele Conkling, School Nurse, American Red Cross, Abilene Texas.
Ethel Parmenter, Resident School Nurse, Rosemary Hall, Greenwich, Conn.
Winifred Cushing, County Nurse, State Department of Health and Welfare, District Health Office, Dover Foxcroft, Maine.
Eva Lillian Borden, County Nurse, Harding County Health Department, Mosquero, N. Mex.

*To staff positions:*

Maybelle Cranston, Public Health Nursing Association, Cedar Rapids, Iowa.
Edna R. Gilbert, Community Health and Civic Association, Ardmore, Penna.
Elizabeth Marshall, Montclair Bureau of Public Health Nursing, Montclair, N. J.
Mrs. Louise F. Sandstrom and Camilla Danforth, Demonstration Nurses, Lambert Corp., New York, N. Y.

### ASSISTED PLACEMENTS

Norma Eskil, Director Nurse, Department of Public Health, Flint, Mich.
Olive M. Nicklin, Visiting Nurse, American Red Cross, Sacramento, Calif.
Cynthia Dauch and Jean South, Staff Nurses, Association for Improving the Condition of the Poor, New York, N. Y.

As was reported in our December number, Anna L. Tittman has accepted the position of Executive Director at the Nurse Placement Service in Chicago. She went to Chicago on January 1. A farewell tea in her honor was arranged on December 13 through the N.O.P.H.N. by her many friends in New York, and a little gift was presented to her.

For the time being, Mary Louise Foster, who has been assisting Miss Tittman for the last seven months, will carry on vocational and guidance service

at the J.V.S. The N.O.P.H.N. is hoping to work out a plan of coöperation with the Nurse Placement Service after Miss Tittman is settled in Chicago, but at present all services will continue as usual from the J.V.S.

## BUILDING BIOGRAPHIES

OVER 9000 public health nurses have had their professional histories compiled by the vocational service sponsored by the N.O.P.H.N. during the fifteen years that the organization has maintained a specific vocational department. These records go to make up a safety depository at an approximate cost of $8 a record, or something over $72,000 in all. The organization has kept such records up to date when nurses have provided data from time to time, as on the occasion of the reopening of a closed record to be placed in the active file when the nurse wishes to be referred to positions.

The records become the property of the J.V.S. and constitute a valuable investment in vocational processes. The assembling of these records is a tangible service offered to members and prospective members of the N.O.P.H.N. They will always be safeguarded, and no nurse, once having had her record assembled, needs to have it duplicated. Records are sent out upon the request of a candidate or an employer, independently of the referral of that nurse for a specific position by the J.V.S. At present there is no registration fee or charge for the use of a record except when the J.V.S. takes the initiative in referring the nurse, and a placement results. It has always been a policy to exchange records with other vocational agencies, organized on a non-profit-making basis under the auspices of some branch of the profession, but they are not exchanged with commercial agencies.

The data furnished by the nurse on the application form of the agency constitute the basic foundation for her professional biography. Roughly, this is divided into three parts: (1) certain personal data, such as name, date of birth, color, and marital state, (2) a statement of details of academic and professional education, (3) confidential references. The nurse's ability to fill out the forms carefully and adequately usually foretells a good deal about her ability to carry out instructions, and her record keeping in her prospective job. Additional data, such as college courses in public health nursing and related subjects, are added when the nurse submits them, and they are desired by some employers. The J.V.S. has never seen its way clear to require a statement by the nurse, setting forth things which would help in evaluating her as an individual, describing her non-professional and professional interests outside of her immediate job, such as her leisure-time activities and reading. This may come in the future, though it is important not to have the record too ponderous.

The objective of a vocational biography is to obtain a composite picture of the nurse in accurate and frank terms to be used in the evaluation of her qualifications by the vocational service for referral to opportunities, and by prospective employers in visualizing her in jobs.

ANNA L. TITTMAN, R.N.
*Vocational Secretary*

## INSTITUTES—INSTITUTES—INSTITUTES

THE N.O.P.H.N. is planning to arrange a series of institutes on various subjects on Saturday and Sunday, April 23 and 24, 1938, in Kansas City, Missouri, just preceding the Biennial Convention. Reservations must be made before April 1 with the N.O.P.H.N. office in New York. Attendance in each institute (except when specified) will be limited to 60, and the institute will not be given unless at least 30 register. To spread attendance at each institute as fairly as possible, representation from an agency will be limited to one person, if 60 are registered. The institutes are open to nurse or lay members of the N.O.P.H.N. You will be notified of your acceptance for an institute by April 1. The following institutes will be given:

RECORDS AND STATISTICS under the auspices of the N.O.P.H.N. Records Committee, conducted by Anna J. Miller, N.O.P.H.N. Statistician. Open to executives acting as supervisors, to supervisors, educational directors, registrars, and statisticians.

Sessions: Saturday, April 23, 9:30-12:00
2:00- 4:00
Sunday, April 24, 2:00- 4:30
Registration fee: $3.00

SYPHILIS AND GONORRHEA under auspices of the N.O.P.H.N., conducted by Mrs. Evangeline Hall Morris, Instructor, School of Nursing, Simmons College, Boston, Massachusetts. Open to nurses working in the program for the control of syphilis and gonorrhea.

Sessions: Saturday, April 23, 9:30-12:00
2:00- 4:00
Sunday, April 24 2:00- 4:30
Registration fee: $3.00

MATERNITY under the auspices of the Maternity Center Association, conducted by Anita Jones.

Sessions: Saturday, April 23, 9:30-12:00
2:00- 4:00
Sunday, April 24, 2:00- 5:00
Registration fee: $3.00

SCHOOL NURSING under the auspices of the N.O.P.H.N. School Nursing Section, Lula P. Dilworth, chairman. Conducted by Marie L. Swanson, State Supervisor of School Nursing, New York State Department of Education. Open to nurses participating in school nursing.

Sessions: Saturday, April 23, 9:30-12:00
2:00- 4:00
Sunday, April 24, 2:00- 4:30
Registration fee: $3.00

TUBERCULOSIS under the auspices of the National Tuberculosis Association, conducted by Philip P. Jacobs, Ph.D., Director, Publications and Extension, National Tuberculosis Association. Planned especially for nurses who are including tuberculosis in a generalized service rather than for those who are specialists. Attendance limited to 150.

Sessions: Saturday, April 23, 9:30-12:00
2:00- 4:00
Sunday, April 24, 2:00- 4:30
Registration fee: $3.00

BUSINESS AND OFFICE ADMINISTRATION under the auspices of the N.O.P.H.N. business office. Leader, Lucretia H. Royer, N.O.P.H.N. Business Manager. Assistance from experts in the field will be announced later. Open only to executives, supervisors, office and business managers, and officers of the boards of private agencies which are member agencies of the N.O.P.H.N. Topics presented will be those sent in by the registrants.

Session: Sunday, April 24, 2:00- 5:00
Registration fee: $3.00

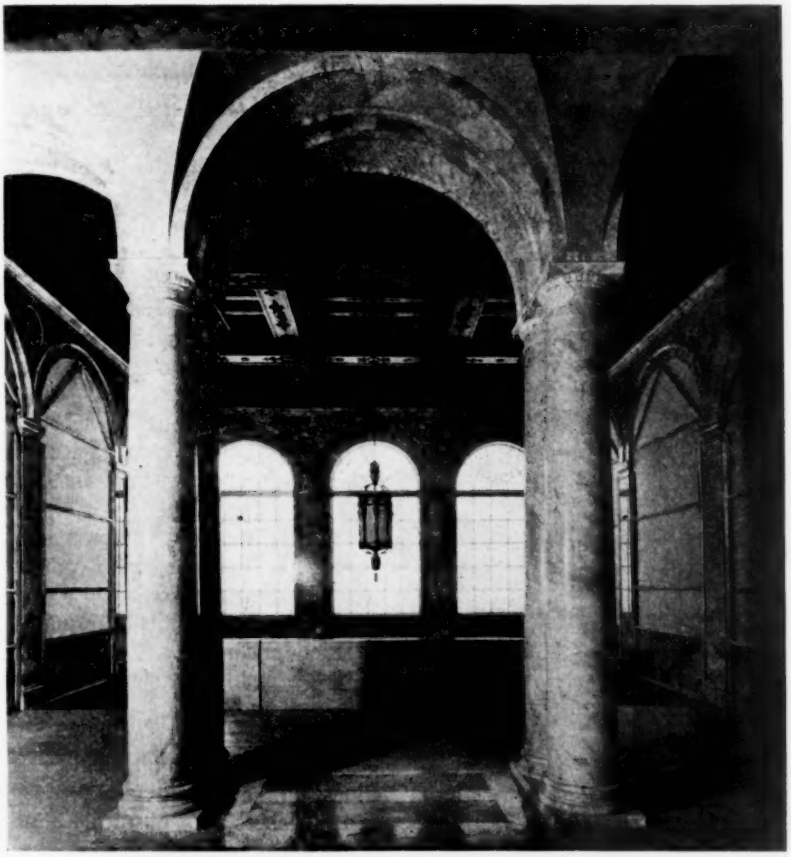
---

Registrations stating name, address, positions, N.O.P.H.N. membership, name of institute, and registration fee should reach the N.O.P.H.N. office, 50 West 50 Street, New York, N. Y., *before April 1.* Registrations will be accepted in order of application and notification will be sent of acceptance.

## ACCOMMODATIONS FOR SPECIAL GROUPS AT THE BIENNIAL CONVENTION

Sister Henrietta, the Chairman of the Local Committee on Catholic Sisters for the Biennial Convention in Kansas City, reports that she plans to have all Sisters housed in Roman Catholic institutions. Reservations for rooms should be made through the Convention Bureau just as other room reservations are, indicating however that a reservation for a Catholic Sister is desired. Sister Henrietta will take care of making the room assignments for all of the Sisters.

Miss Alexander, Chairman of the Sub-committee on Negro Nurses for the Biennial Convention, asks that all Negro nurses who are planning to attend the Biennial get in touch with her for housing accommodations. Her address is Princess Alexander, President of the Pan-Missouri State Nurses' Association, 1836 Forest Avenue, Kansas City, Mo.



**Stairway interior—William Rockhill Nelson Gallery of Art and Mary Atkins Museum, Kansas City, Missouri.**

**THE BIENNIAL CONVENTION, APRIL 24-29.**


## MAKING THE LUNCHROOM EDUCATIONAL

"To provide a basis for setting up standards that are essential in school lunchrooms if the latter are to function in the health education program of schools, the health education committee and the school cafeteria committee of the American Home Economics Association coöperated during the school year 1934-35 in a study of the present situation in school lunchrooms."

Following this study the committee made the following recommendations:

1. That a trained director of school lunches be employed.
2. That optimum service rather than profit should be the motive in conducting school lunches.
3. That adequate attractive lunches be available for all children and that they be served in pleasant, sanitary surroundings.
4. That the lunchrooms function as integral factors in the health education program.

The following suggestions were reported for promoting good food selection:

1. Menus that appeal to and suit the needs of growing children.
2. A good variety of low cost food.
3. Well planned plate lunches which include at least one very popular food.
4. Milk, fruit, and vegetables sold at as nearly the cost as possible with less desirable foods relatively high in price.
5. Limit or eliminate the sale of candy.
6. At least a twenty-minute lunch period with staggered lunch hours to avoid crowding.
7. Posters and exhibits to encourage good food selection.
8. Supervision of food selection by nurse, food director, or advanced students in home economics. Good selection may be rewarded by placing an "A" card on the tray.
9. Printed slips on trays suggesting good lunches.
10. Publish menus in school paper or post on bulletin board a week in advance so that they may be discussed with the children.
11. Send menus to parents a week in advance so that they may coöperate in securing adequate dietary.
12. Classes in nutrition planned to parallel lunchroom activities.
13. Assembly programs related to nutrition.
14. Conferences between food directors and school administrators, health education directors, medical advisers, and teachers of physical education, science, and home economics to evaluate lunchroom practices and plan improvement.
15. Surveys of health status of chil-

dren as a basis for planning needed improvements.

16. Education of parents through letters, printed materials, study groups on nutrition and meal planning for developing good food habits, and through the participation of parents in surveys.

---

Condensed from "A Survey of School Luncheons," by Dora S. Lewis and Phyllis Sprague, *The Journal of Home Economics*, November 1936, reprinted in *School Management*, February 1937.

---

## SCHOOL HEALTH STUDIES

The Education Committee of the School Nursing Section of the National Organization for Public Health Nursing is interested to know of any studies recently completed or now being made of problems in school nursing, in order that the Committee may summarize these studies and refer to them in its reports. All nurses knowing of such studies are asked to communicate at once with the N.O.P.H.N., 50 West 50 Street, New York, N. Y., stating the following:

1. Purpose and description of problems being studied.
2. Methods of making the study.
3. Names of individuals or groups participating in the study.
4. Summary and conclusions of completed studies.
5. Probable date of conclusion of unfinished studies.

**See also "Health Education Materials" by Mary P. Connolly, page 22.**


EDITED BY
ELEANOR W. MUMFORD

### PERSONNEL POLICIES IN PUBLIC HEALTH NURSING

By Marian G. Randall. 184pp. The Macmillan Company, New York. $2.

A valuable contribution to the growing literature of public personnel administration is a book by Marian G. Randall entitled, *Personnel Policies in Public Health Nursing*. Prepared for the Committee on Personnel Practices in Official Agencies of the National Organization for Public Health Nursing, this study compiles and analyzes data from fifty-nine official agencies scattered throughout the country and operating on all levels of government. Approximately two thousand tax-supported nurses, out of twelve thousand in the profession, are included in the sample data selected.

The book indicates that there has been considerable improvement in the educational qualifications of directors, supervisors, and staff nurses compared with 1931 when a similar survey was made. "Those who have worked for better preparation of public health nurses should be very much encouraged by this comparison," the author states. As is frequently true in positions other than public health nursing, some of the smaller agencies employ people who are below satisfactory standards. This is unfortunate since the smaller agencies provide less supervision, and individual staff members have more responsibility.

Of the agencies supplying data, twenty-five were under civil service and thirty-four were not. While some civil service agencies are making an effort to attract well qualified personnel, the study indicates that the quality of the staff is not measurably better in the civil-service jurisdiction, taken as a whole, than in the non-civil-service ones. The conclusion would seem to be that civil service agencies are not raising their qualifications to the extent that the supply of trained and experienced personnel justifies.

The personnel practices recommended to official agencies are in line with the best methods and policies of public personnel administration. If the agencies will use the advice contained in this book on position classification, examinations, the probationary period, service or efficiency ratings, promotions, and other aspects of personnel administration, the public health nursing profession will be one of the choice fields of public employment.

This book includes many tables of interesting statistical data relating to public health nursing. Some of the information in regard to civil service contains inaccuracies, but they are not important enough to damage the study in any serious manner.

H. M. STOUT

*Senior Staff Member, Civil Service Assembly of the United States and Canada*

### FEEDING BEHAVIOR OF INFANTS

**A Pediatric Approach to the Mental Hygiene of Early Life.**

By Arnold Gesell, Ph.D., M.D., Sc.D., and Frances L. Ilg, M.D. 210pp. J. B. Lippincott Company, Philadelphia, 1937. $4.50.

Dr. Gesell has this time taken up his "goldfish globe" babies primarily from the point of view of their feeding behavior, although they turn out to be the same babies that we have viewed with him before from other angles. There is apparently, as might be expected, a close interrelationship between feeding behavior and personality factors.

The observation age periods are

seven in number, beginning with the fetal period, from the seventh to the fortieth post-conception week, and ending with the second year. The reactions of the infant to its food are classified under three headings: adjustment to presentation, feeding patterns, and satiety and rejection. By the study of these reactions in these age groups, normative trends in behavior growth are ascertained. A great deal of material has been studied in this investigation, by direct observation, by cinema analysis, and by behavior day-charts.

Certain very valuable and fundamental lessons are to be learned from the study, important to parents and to all others who have to do with the care and training of infants. It is apparent that we have gone too far in trying to regulate the lives of those whose lives should be regulated largely by their personal needs. The necessity that we feel of fixing schedules creates tension and conflicts; the infant "cannot live completely by a clock on the wall because his organic needs are intrinsically regulated by his own internal time mechanisms." The self-demand schedules of feeding and sleeping, instead of encouraging whims and instabilities, actually help to stabilize the infant.

Others of our adult-devised concepts should also go by the board. Instead of forcing food upon an unwilling subject the signs of satiety should be recognized and respected; anorectic infants, however, cannot be starved into developing appetites, although the attempt to do this is now almost universal practice. Finger feeding, far from being a disgusting habit, is a normal developmental phenomenon. Thumb or fist sucking, particularly during the first year, is probably as natural as sucking on the nipple; it is when we try to break so-called bad habits that we are most likely to fix them.

Bowel and bladder control are not acquired nearly as early as our wishful thinking leads us to expect them to be. The child gradually assumes increasing responsibility for himself, but too much should not be expected during the first two years.

This study brings us face to face with an axiomatic principle that we are far too prone to forget—that we must learn before we try to teach.

JOSEPH GARLAND, M.D.
*Boston, Massachusetts*

### PERSONAL HYGIENE

By Clair Elsmere Turner, Dr.P.H. 306pp. The C. V. Mosby Company, St. Louis, 1937. $2.25.

A year and a half ago Dr. Turner's *Personal and Community Health* came out in a new edition. It has been considered by many as one of the best textbooks which has yet appeared for the college level. The present volume, *Personal Hygiene*, is prepared especially for those teachers who deal with personal but not community health.

The book is concise and covers the important aspects of the subject with sufficient use of anatomy, physiology, and the other sciences to support the health teaching. In orderly procedure the various systems of the body are taken up and their related hygiene discussed. There are separate chapters on heredity, narcotics and stimulants, and mental hygiene. In the light of changing public and educational opinion as to discussions of sex hygiene, one wonders why Dr. Turner thought best to omit a scientific presentation of birth control and of the physiology of the sex act in his chapter on reproduction. It may be that he feels the foundation for such a discussion has not yet been adequately laid in our lower grades, and that in so small a volume it cannot be adequately presented.

Perhaps because the inclusion of the topics on community health in Dr. Turner's first book proved to be so valuable, it is regretted that this volume restricts itself to the hygiene of the in-

dividual alone, particularly since material with social implications is apt to bring a response from the college-age group. Yet as Dr. Turner says, there are difficulties in writing on hygiene, for "the field is broad, the science is advancing rapidly," and it is impossible to include everything in 306 pages. For that very reason one questions the author's references to a Supreme Being. In a hygiene book strictly limited to the field of personal hygiene such a reflection of the author's personal beliefs is an intrusion, in the eyes of some of our critical collegians.

The book is written in a clear, didactic style with useful diagrams and illustrations. It is as good a standard text as we have in this important and debatable field.

JANE FOSTER, R.N.,
*Smith College*
*Northampton, Massachusetts*

### SALARIES OF SCHOOL EMPLOYEES, 1936-37

Research Bulletin of the National Education Association. 1201 Sixteenth Street, Northwest, Washington, D. C., March 1937. 86pp. 25c.

This report presents the results of the last biennial survey of salaries of city school employees, including nurses. Median salaries for each of the preceding years since 1930-1931 are also given to indicate trends. The data were gathered by questionnaire forms distributed to superintendents of schools, and it is estimated that 85 percent of all employees in city school systems are included in the tabulations. (In a supplement some data are included relative to salaries paid in rural schools, and a statement is made that a more comprehensive study of such salaries is planned.)

A conclusion which is of interest is that the median salaries paid all types of such employees decreased from the school year of 1930-1931 to that of 1932-1933, and decreased still further in 1934-1935. In practically every type of position, 1936-1937 salaries are higher than those of 1934-1935. The median salary of school nurses in cities of over 100,000 population is $1706, and it decreases for each of the population groups considered; in cities of 2500 to 5000 population it is $1216. In the largest cities the median is only one half of one percent below the 1930-1931 figure; in the smaller cities recovery of salaries for all school positions studied has been less rapid; the median salary for nurses in the group from 2500 to 5000 population is 21 percent below that of 1930-1931. A.J.M.

### REPORT OF THE COMMITTEE ON TUBERCULOSIS AMONG NEGROES*

**A Five-Year Study and What It Has Accomplished**

By The Committee on Tuberculosis Among Negroes. 77 pp. National Tuberculosis Association, New York, 1937.

This is the report of a study made possible by a grant from the Julius Rosenwald Fund. The field secretary for the study was Dr. Cameron St. C. Guild. The principal objectives were:

1. To stimulate interest in the problem of tuberculosis among Negroes.
2. To investigate current administrative practices in the control of tuberculosis among Negroes and to secure wider utilization of effective procedures.
3. To devise new techniques which would be of help.

The tuberculosis mortality rate among Negroes in various parts of the country was found to be from three to six times greater than for white people. This forms a serious health problem not only for the colored race but for the entire community.

Recommendations of the study include:

1. Increased health education for Negroes.
2. More diagnostic clinics, more sanatorium beds and other treatment facilities.
3. Development of Negro leadership.
4. Use of trained Negro personnel with special emphasis placed on the value of the colored public health nurse. R.H.

*May be secured from your state or local tuberculosis association.

## RECENT PUBLICATIONS AND CURRENT PERIODICALS

### ADMINISTRATION

CASE RECORDS AS AN INDEX OF THE PUBLIC HEALTH NURSE'S WORK. Helen Bean and Emily Hankla. *Public Health Reports*, U. S. Public Health Service, August 6, 1937, p. 1077. For sale by the Superintendent of Documents, Washington, D. C., 5c.

This study of the case records of three county health departments leads to some interesting conclusions as to how adequately they reflect the actual service rendered.

LIFE BEGINS AT FORTY. *Nursing News*, The Connecticut State Nurses Association, Inc., 252 Asylum Street, New Haven, Conn., October 1937, p. 9.

The Connecticut State Nurses Association reports a health and accident insurance plan for its members.

GENERALIZED PUBLIC HEALTH NURSING. Genevieve McKinney. *The National News Bulletin* (Official Organ of the National Association of Colored Graduate Nurses, 50 West 50 Street, New York), October-November 1937, p. 1.

An interesting presentation of the subject very simply told.

SELECTED LIST OF PUBLICATIONS. Publication No. 12, The Social Security Board, Washington, D. C., March 1937. 15pp. Free.

This list contains a brief description of all printed material issued to the general public by the Social Security Board, as well as certain publications of other government departments concerned with the administration of the Social Security Act.

QUESTIONS AND ANSWERS ABOUT COMMUNITY CHESTS AND COUNCILS OF SOCIAL AGENCIES. Community Chests and Councils, Inc., 155 East 44 Street, New York, 1937. 27pp. 25c.

Based on actual inquiries, answered by the national association. This pamphlet will be of interest to board and committee members and to directors of public health nursing services.

DISTRICT HEALTH ADMINISTRATION. A Study of Organization and Planning. Ira V. Hiscock. Milbank Memorial Fund, 40 Wall Street, New York, 1936. 115pp. 65c.

This study of the decentralization of certain health department functions is based primarily on the experience of New York City, with references to some other large cities.

### BOARD, COMMITTEE, AND VOLUNTEER PROGRAMS

THE ROLE OF THE LAYMAN. *News Bulletin*, Community Chests and Councils, Inc., 155 East 44 Street, New York, June 1937, p. 20. Subscription price $1.50 per year.

A very interesting summary of the discussion at the Indianapolis meeting of the National Conference of Social Work, on lay participation in the field of social work. Contains quotations from speeches prepared directly on that subject, and also from speakers presenting other subjects—who were constantly pointing out that social work can only advance in the community through the coöperative effort of both the lay and the professional workers.

PUBLIC WELFARE BOARD AND COMMITTEE RELATIONSHIPS. R. Clyde White. American Public Welfare Association, 850 East 58 Street, Chicago, June 1937. 23pp. 35c.

This is a handbook for public welfare boards written, of course, primarily for the tax-supported agency, but which has very interesting material in it for the private agency.

ON BEING A BOARD MEMBER. Robert G. Paterson, Ph.D. National Tuberculosis Association, New York, 1937. 12pp. May be secured from your state or local tuberculosis association.

This discusses briefly qualifications, term of office, committees, and relationships.

GUIDE FOR MEDICAL SOCIAL SERVICE COMMITTEES. United Hospital Fund of New York, 1937. 34pp.

A handbook on the functions and activities of medical social service committees. Although written primarily for a particular group it has significance for all committees, and boards of visiting nurse associations should be in touch with the program of the medical social service committees in the hospitals.

WHY AND WHEREFORE. Clarence King. *Survey Midmonthly*, November 1937, p. 342.

A discussion of the reasons and purposes of boards. This is to be one of four articles that are to be published in the *Survey Midmonthly*. These chapters from a book by Mr. King on the subject of the board member will soon be published by Harper and Brothers, New York.


• The sixty-seventh meeting of the American Public Health Association will be held in Kansas City, Mo., October 25-28, 1938. Dr. Edwin Henry Schorer, Director of the Kansas City Health Department, has been appointed Chairman of the Local Committee.

• The weekend of January 29-31 has been designated Child Labor Day by The National Child Labor Committee. Child Labor Day was instituted 32 years ago. It is an occasion on which a nationwide drive is made each year to arouse public opinion against the disgrace of child labor. Those interested in arranging child labor talks, plays, and programs in churches, schools, and clubs may obtain literature for this purpose from The National Child Labor Committee, 419 Fourth Avenue, New York, N. Y.

• Plans for a study of the eye health problems of college students are being made by the Eye Health Committee of the American Student Health Association with the aid of an Advisory Committee from the American Academy of Ophthalmology. The project will have the coöperation of the National Society for the Prevention of Blindness.

• On November 26, the March of Time released a dramatization of *The Human Heart* in all the larger cities in the country. The picture stresses the need of frequent examination of the heart. The American Heart Association assisted in the production of this film, as did consultants of Rockefeller Institute, New York University College of Medicine, Yale University, and Western Reserve University.

• Dr. Edmund Prince Fowler, retiring president of the American Otological Society, has been elected president of the American Society for the Hard of Hearing, Washington, D. C.

• The first New York State Institute of Public Housing, called by the National Housing Conference and sponsored by 60 organizations, held a two-day meeting at the Astor Hotel, New York, N. Y., November 12 and 13. The speakers at the three sessions discussed how the Wagner Public Housing Act will help both urban and rural communities in solving their housing problems. The opening dinner meeting on November 12 was in honor of Senator Robert F. Wagner, the father of the Housing Act.

• Miss Eula Butzerin, at present Director of the public health nursing course at the University of Minnesota, has been appointed Associate Professor of Nursing Education at the University of Chicago, to develop curricula in public health nursing for graduate nurses.

• Announcement has been made of two more appointments to the staff of the New York World's Fair of 1939. Dr. Joseph Peter Hoguet was made administrative assistant and medical director, and in this position he will be in charge of the executive and administrative work of the Division of Public Health, Medicine, and Sanitation. Dr. Valeria H. Parker, American Social Hygiene Association consultant and during the past year director of the Institute on Marriage and the Home of the Oranges, New Jersey, has been appointed chairman of the Protective Committee.

• The Maternity Center Association in coöperation with the Department of Nursing Education of Teachers College announces a two-months' program of advanced maternity nursing for a limited number of maternity supervisors in the field of public health nursing. Included in the program will be lectures on obstetrics, community maternity nursing, and other subjects affecting the care of maternity patients; supervised field observation; round table discussion of administrative and other problems; assigned reading; and study hours. To register, write directly to the Maternity Center Association, 1 East 57 Street, New York, N. Y., giving your name, address, and position held. Registration will be closed on January 20, or sooner if sufficient students register. Students not applying for credit will be charged a flat registration fee of $50. Students may live at Whittier Hall, a woman's dormitory of Teachers College, where the minimum cost for rooms and meals is $12.75 a week. This unit is not to be confused with the four-months' and eight-months' courses in advanced maternity nursing offered regularly by Teachers College in conjunction with the Maternity Center Association.

### NEW APPOINTMENTS

*(For J.V.S. Appointments see page 52)*

Bessie Nicoll, Director of Home Hygiene and Care of the Sick, Toledo Chapter, American Red Cross, Toledo, Ohio.

Anne Poore, Educational Director, Polk County Health Unit, Des Moines, Iowa.

Elizabeth Reynolds, Consultant Supervisory Nurse, Nashoba Health District, Ayer, Mass.

Catherine M. McDermott, Supervisor, Instructive Visiting Nurse Society, Washington, D. C.

Mabel Johnson, Orthopedic Supervisor, Division of Crippled Children, State Department of Public Welfare, Helena, Mont.

Martha Douglass, School Nurse and Instructor in Health Education, Wheaton Public Schools, Wheaton, Ill.

Clara E. Smith, Nurse Social Worker, Department for the Prevention of Disease, Children's Hospital of Philadelphia, Philadelphia, Penna.

Jeannette Oppliger, Public Health Nurse, Sacramento City Health Department, Sacramento, Calif.

Evelyn Sutherland, Department of Health and Welfare, Las Vegas, N. Mex.

Frances D. Amborski, School Nurse, Two Rivers, Wisc.

Helen Cromwell, Senior Nurse, Des Moines County Health Unit, Des Moines, Iowa.

Victoria Kavooghian, Community Health Association, Boston, Mass.

Ruth M. Swanson, Community Health Association, Boston, Mass.

Mrs. Ruth J. Davis, Henry Street Visiting Nurse Service, New York, N. Y.

Bernadine Berlin, Visiting Nurse Association, Erie, Penna.

Margaret E. Peters, District Nursing Association, Lawrence, L. I., N. Y.

Marguerite Barrett, Visiting Nurse Service, Hartford, Conn.

Mrs. Joan M. Hewitt, Henry Street Visiting Nurse Service, New York, N. Y.

Beatrice Nichols, Department of Health, Washington, D. C.

Hilda Cabaniss, Children's Fund of Michigan, Detroit, Mich.

Julia D. Smith, Field Nurse, Rutherford County Health Department, Tenn.

Marian Ruth Carlisle, Community Nurse, Guilford Public Health Nursing Association, Guilford, Conn.

Mary Frances Dill, School Nurse, Vacaville High School, Vacaville, Calif.

Mildred Farrell, School Nurse, Blasdell, N. Y.

Mrs. Charlotte Ehling, School Nurse, Mendocino County, Calif.

Frieda Krehbiel, School Nurse and Territorial Nurse, Ketchikan, Alaska.

Cecilia Sally Yash, Family Health Counsellor, W. K. Kellogg Foundation, Battle Creek, Mich.

Janice Ayres, Staff Nurse, Community Health Society, Swarthmore, Pa.

Marjory Bohart, Public Health Nurse, Umatilla County Health Unit, Pendleton, Ore.

Mrs. Ethel Grandy, Public Health Nurse, Pend Oreille County, Wash.

Marguerite Collyer, School Nurse, Lake Mahopac, N. Y.

Mrs. Florence A. O'Connor, Staff Nurse, Pittsburgh Public Health Nursing Association, Pittsburgh, Pa.

### NOTICE TO SUBSCRIBERS

Changes of address must reach us before the 15th of the month in order to be used for the current magazine. Please add forwarding postage to magazines which are readdressed; otherwise your magazine comes back to us collect and we have to pay both return postage and remailing charges.

# Study Page for January

**Suggestions for Board Members, Executives, Staff Nurses, and Students**

The following questions are based on the published material in this number, and offer suggestions for the use of the magazine:

*Board Members*

What are some prerequisites for an organization which takes student nurses for public health nursing experience? *Student Affiliation with a Public Health Nursing Agency.* Page 15.

What are several rules of health which will help to avoid preventable illness in adults? *Adult Hygiene.* Page 34.

How can a community assure itself of adequate and satisfactory nursing service? *Councils on Community Nursing.* Page 26.

What are some of the activities which volunteers carry on in public health nursing agencies? *A Study of Volunteer Service.* Page 38.

*Executives and Supervisors*

What prerequisites for student affiliation are important: (1) for the public health nursing agency, (2) for the school of nursing? See question 1 under Board Members.

What are some assets and liabilities of volunteer service? What training do agencies give to volunteers? See question 4 under Board Members.

How can a community analyze its nursing needs and plan to meet these needs? See question 3 under Board Members.

What responsibility has an executive or supervisor for the growth of her workers? *New Jobs for Old.* Page 11.

What techniques for exchanging ideas and viewpoints have the agencies in your community developed—within the local community and with other parts of the country? *"New Year."* Page 2.

*Staff*

When should a nurse change from one job to another? See question 4 under Executives and Supervisors.

What are the advantages and disadvantages of rural public health nursing as compared to similar work in the city? *How Rural Nurses Live.* Page 19.

What are some sources of health education materials for secondary schools? *Health Education Materials.* Page 22.

Who is responsible for planning the nursing program in a county unit? *A Rural Health-Program in the Northwest.* Page 3.

What do you include in the teaching content of your health supervision of adults? See question 2 under Board Members.

*Students*

What opportunities for personal and professional growth are offered in public health nursing today? See question 4 under Executives and Supervisors and question 2 under Staff.

What kinds of health activities are carried on by a county health unit? What other organizations does the health department work with in order to carry out its program? See question 4 under Staff.

What suggestions could you give to "grown-ups" regarding the care of their health in order to avoid preventable illness? See question 2 under Board Members.

# Official Directory of Public Health Nurses

*Listing those holding executive positions in the Federal Government, in national organizations, and in states and territories, officers of state organizations for public health nursing and public health nursing sections of state nurses' associations, and directors of public health nursing courses*

Information as of December 1, 1937, unless otherwise stated.

**The National Organization for Public Health Nursing, Inc.**

President, Amelia Grant, Department of Health, New York, N. Y. General Director, Dorothy Deming, 50 West 50 Street, New York, N. Y.

**American Red Cross, Nursing Service**

Public Health Nursing and Home Hygiene and Care of the Sick Service—National Director, I. Malinde Havey, American Red Cross, National Headquarters, Washington, D. C.

*Eastern Area*

*(All to be addressed at American Red Cross, National Headquarters, Washington, D. C.)*

Assistants to the National Director:

Margaret E. Dizney (On leave of absence)
Anna C. Gring
Charlotte M. Heilman
Annabelle Petersen—Florida, Georgia, Indiana, Ohio, Virginia, West Virginia.
Eugenia Klinefelter—Alabama, Kentucky, Louisiana, Massachusetts, Mississippi, North Carolina, Rhode Island, South Carolina, Tennessee.
Marie Peterson—Connecticut, New Hampshire, New York, Maine, Vermont.
Mary DeLaskey—Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania.

Nursing Field Representatives:

Bertha Allwardt—New York.
Zella Bryant—Kentucky, Louisiana, Mississippi, Tennessee.
Miriam A. Dailey—Indiana, Ohio, Virginia, West Virginia.
Alice Dugger—Alabama, Florida, Georgia, North Carolina, South Carolina.
Elizabeth Hill—Delaware, District of Columbia, Maryland, Pennsylvania.
Katherine R. Murphy—Massachusetts, Rhode Island, Vermont.
Cecelia Walsh—Maine, New Hampshire.
Mary E. Beam—New Jersey.

*Midwestern Area*

*(All to be addressed at American Red Cross, 1709 Washington Avenue, St. Louis, Mo.)*

Director, Lona L. Trott

Assistants to the Director:

Ella B. Gimmestad—Iowa, Michigan, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wisconsin, Wyoming.
Thora Ingebritson—Arkansas, Colorado, Illinois, Kansas, Missouri, New Mexico, Oklahoma, Texas.

Nursing Field Representatives:

Rebecca Pond—Illinois, Michigan, Minnesota, Wisconsin.
Theresa Campbell—Arkansas, Missouri, Oklahoma, and visiting nurse services in other states.
Beatrice Kinney—Iowa, Montana, Nebraska, North Dakota, South Dakota, Wyoming.

*Pacific Area*

*(All to be addressed at American Red Cross, Civic Auditorium, Larkin and Grove Streets, San Francisco, Calif.)*

Director, Gladyce Badger

Nursing Field Representative, Myrtis Coltharp—Idaho, Nevada, Oregon, Utah, Washington.

**National Association of Colored Graduate Nurses, Inc.**

President, Mrs. Estelle M. Riddle, 672 Euclid Avenue, Akron, Ohio.
Executive Secretary, Mabel K. Staupers, 50 West 50 Street, New York, N. Y.

**U. S. Department of the Interior**

Bureau of Indian Affairs

Director of Nursing, Elinor D. Gregg, Office of Indian Affairs, Department of the Interior, Washington, D. C.
Associate Public Health Nursing Consultant, Rosalie I. Peterson, Office of Indian Affairs, Department of the Interior, Washington, D. C.

District Supervisory Nurses:

Mary E. McKay, Office of Indian Affairs, Department of the Interior, Washington, D. C.
Mabel L. Morgan, 161 Federal Office Building, Minneapolis, Minn.
Sallie Jeffries, 404 Federal Building, Spokane, Wash.
Bertha M. Tiber, Juneau, Alaska.

**U. S. Department of Labor**

Children's Bureau, Public Health Nursing Unit—Director of Public Health Nursing, Naomi Deutsch, Children's Bureau, Department of Labor, Washington, D. C.

*Regional Public Health Nursing Consultants and Territory*

*(To be addressed at Children's Bureau, Department of Labor, Washington, D. C.)*

Hortense Hilbert—Maine, New Hampshire, Vermont, Massachusetts, New York, Connecticut, Rhode Island, Pennsylvania, New Jersey.

Ruth Heintzelman—Maryland, Delaware, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida, District of Columbia.

Jane Nicholson—Illinois, Indiana, Ohio, Iowa, Michigan, Minnesota, Wisconsin, North Dakota, South Dakota, Nebraska.

Ruth Cushman, Room 1048 Canal Bank Building, 210 Baronne Street, New Orleans, La.—Kentucky, Tennessee, Alabama, Louisiana, Arkansas, Mississippi, Oklahoma, Texas, Kansas, Missouri.

Ruth Taylor, Room 1206 Humboldt Bank Building, 785 Market Street, San Francisco, Calif.—Arizona, New Mexico, Colorado, Montana, Wyoming, Idaho, Nevada, California, Oregon, Washington, Utah, Territories of Alaska and Hawaii.

**U. S. Department of the Treasury**

Bureau of the Public Health Service, Public Health Nursing Service

Senior Public Health Nursing Consultant, Pearl McIver, Public Health Nursing Section, Domestic Quarantine Division, Washington, D. C.

Public Health Nursing Consultant, Helen Bean, Public Health Nursing Section, Domestic Quarantine Division, Washington, D. C.

*Regional Public Health Nursing Consultants and Territory*

Mary D. Forbes—Sub-Treasury Building, Wall, Pine, and Nassau Streets, New York, N. Y.—Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, New York, New Jersey, Pennsylvania.

Mary J. Dunn—Navy Building, Nineteenth and Constitution Avenue, Washington, D. C.—Delaware, Maryland, West Virginia, Virginia, North Carolina, South Carolina, Georgia, Florida, District of Columbia.

F. Ruth Kahl—Room 314, U. S. Court House, Chicago, Ill.—Ohio, Indiana, Illinois, Michigan, Wisconsin, Iowa, Minnesota, Nebraska, North Dakota, South Dakota.

Donna Pearce—Room 302, U. S. Marine Hospital, New Orleans, La.—Alabama, Mississippi, Louisiana, Tennessee, Kentucky, Missouri, Arkansas, Oklahoma, Kansas, Texas.

Anna Heisler—Room 204, Federal Office Building, San Francisco, Calif.—California, Oregon, Washington, Idaho, Nevada, Utah, Montana, Wyoming, Colorado, New Mexico, Arizona.

**U. S. Veterans' Administration**

Veterans' Administration Nursing Service—Superintendent of Nurses, Mrs. Mary A. Hickey, Veterans' Administration, Washington, D. C.

## ALABAMA

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Mrs. Sarah Brooks Jones, State Health Department, Montgomery. Vice-Chairman, Mrs. Rachel Easter, Florence.

**State Nurses' Association** Paid Executive—Anne Beddow, 1601 North 25 Street, Birmingham.

## ARIZONA

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Mrs. Kathryn Vivian, 3323 North Central Avenue, Phoenix. Vice-Chairman, Mrs. Mary Moore, Chandler. Secretary, Julia Hill, Douglas.

**State Board of Health**—Florence Stein, Chief Public Health Nursing Consultant, Division of Local Health Work, Phoenix.

## ARKANSAS

**State Organization for Public Health Nursing**—President, Matie Neely, Morrilton. Secretary, Lila Russell, Clarksville. Treasurer, Mary Sullivan, c/o Peabody College, Nashville, Tenn. Chairman Membership Committee, Mrs. Angie Faye Waldrum, State Board of Health, Little Rock.

**State Board of Health**—Margaret Vaughan, Supervisor of Public Health Nursing, Bureau of Local Health Service, Little Rock.

## CALIFORNIA

**State Organization for Public Health Nursing**—President, M. Louise Floyd, 1218 Menlo Avenue, Los Angeles. Secretary, Mrs. Ethel L. Goldrick, City Hall, Pasadena. Treasurer, Jenet M. Roush, 726 N. Tuxedo, Stockton. Chairman Membership Committee, Helen L. Woodworth, 219 LaCumbre Road, Santa Barbara.

**State Department of Public Health**—Rena Haig, Chief, Division of Public Health Nursing, 305 State Building, San Francisco.

**California Tuberculosis Association**—Irene Carlson, 45 Second Street, San Francisco. Violet Eleagarian, 45 Second Street, San Francisco. Lois E. Haworth, 45 Second Street, San Francisco. Beatrice Woodward, 45 Second Street, San Francisco.

**State Nurses' Association** Paid Executive—Harriott L. P. Friend, Director at Headquarters, Room 309, 609 Sutter Street, San Francisco.

## COLORADO

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Marjorie Guillet, Sterling. Secretary, Virginia Adkins, 3134 South Grant, Englewood.

**State Board of Health**—Ruth Phillips, Director, Division of Public Health Nursing, 424 State Office Building, Denver.

**Colorado Tuberculosis Association**—Vera Knickerbocker, 305 Barth Building, Denver.

**State Nurses' Association** Paid Executive—Irene Murchison, 621 Majestic Building, Denver.

## CONNECTICUT

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Ruth M. Olson, 74 South Burritt Street, New Britain. Vice-Chairman, Gertrude Zurrer, 458 Norman Street, Bridgeport. Secretary, Alice Lawton, 26 Atwood Street, Hartford.

**State Department of Health**—Hazel V. Dudley, Director, Bureau of Public Health Nursing, State Office Building, Hartford.

**State Nurses' Association** Paid Executive—Margaret K. Stack, Room 512, 252 Asylum Street, Hartford.

## DELAWARE

**Section on Public Health Nursing** of State Graduate Nurses' Association—Chairman, Margaret Butler, 2705 Boulevard, Wilmington. Vice-Chairman, Marianne Moore, 225 West 14 Street, Wilmington. Secretary, Josephine Farnham, Delaware State Tuberculosis Sanitarium, Marshallton.

**State Board of Health**—Mrs. Kathryn Trent, Director, Public Health Nursing, Dover.

## DISTRICT OF COLUMBIA

**Public Health Committee** of the Graduate Nurses' Association—Chairman, Marion Ferguson, District Building, Washington.

**District of Columbia Health Department**—Mrs. Josephine Prescott, Director, Bureau of Public Health Nursing, Washington.

**District Nurses' Association** Paid Executive—Emily Kleb, 1746 K Street, Northwest, Washington.

## FLORIDA

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Cynthia May Mabette, Box 827, Ocala. Vice-Chairman, Mrs. Lydia C. Holzscheiter, New Port Richey. Secretary, Norma Diez, Monroe County Health Department, Key West.

**State Board of Health**—Ruth Mettinger, Director, Division of Public Health Nursing, Jacksonville.

## GEORGIA

**State Organization for Public Health Nursing**—President, Mrs. Nell Johnson, Rome. Secretary, Carolyn Tillinghast, Sparta. Treasurer, Annie Higginbothan, Metropolitan Life Insurance Nursing Service, Atlanta. Chairman Membership Committee, Betty Kliensteuber, Savannah Health Center, Savannah.

**State Department of Public Health**—Mrs. Abbie Roberts Weaver, Director, Division of Public Health Nursing, State Capitol, Atlanta.

**State Nurses' Association** Paid Executive—Durice Dickerson, 131 Forrest Avenue, Northeast, Atlanta.

## IDAHO

**State Department of Health**—Mrs. Kathryn McCabe, State Supervising Nurse, Boise.

**Idaho Anti-Tuberculosis Association**—Margaret Thomas, P. O. Box 1703, Boise.

## ILLINOIS

**Section on Public Health Nursing** of State Nurses' Association — Chairman, Dorothea Thompson, 8 South Michigan Avenue, Chicago. Vice-Chairman, Florence Buchanan, 8 South Michigan Avenue, Chicago. Secretary, L. Maude Ryman, 8 South Michigan Avenue, Chicago.

**State Department of Public Health**—(To be filled) Chief, Nursing Division, State House, Springfield.

**State Nurses' Association** Paid Executive—Madeleine McConnell, 8 South Michigan Avenue, Chicago.

## INDIANA

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Maxhine Biebesheimer, 309 Central Building, Fort Wayne. Vice-Chairman, Beth Olmstead, Visiting Nurse Association, Muncie. Secretary, Bernice Cain, 808 Majestic Building, Indianapolis.

**State Board of Health**—Eva MacDougall, Chief, Bureau of Public Health Nursing, Indianapolis.

**State Nurses' Association** Paid Executive—Helen Teal, 717 Circle Tower, Indianapolis.

## IOWA

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Margaret Van Ackeren, State House, Des Moines. Vice-Chairman, Clara Anderson, Toledo. Secretary, Bess Cunningham, Oskaloosa.

**State Department of Health**—Edith S. Countryman, Director, Division of Public Health Nursing, Des Moines.

**Iowa Tuberculosis Association**—Marguerite Pfeffer, 610 Flynn Building, Des Moines. Hazel Rendleman, 610 Flynn Building, Des Moines.

## KANSAS

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Marian Nicholson, 721 Nebraska, Kansas City. Secretary, Mrs. Oma B. Hunter, City Hall, Kansas City.

**State Board of Health**—Mary E. McAuliffe, Supervisor, Public Health Nursing, Division of Child Hygiere, Capitol Building, Topeka.

**Kansas Tuberculosis and Health Association**—Velma G. Long, 824 Kansas Avenue, Topeka.

## KENTUCKY

**State Organization for Public Health Nursing**—President, Bettie McDanald, 604 South Third Street, Louisville. Secretary, Pearl S. Schlosser, 604 South Third Street, Louisville. Treasurer, Mrs. Lucille Fentress, Muhlenberg County Health Department, Greenville. Chairman Membership Committee, Bettie McDanald, 604 South Third Street, Louisville.

**State Department of Health**—Margaret L. East, Director, Bureau of Public Health Nursing, Louisville.

**State Nurses' Association** Paid Executive—Mrs. Myrtle C. Applegate, 604 South Third Street, Louisville.

## LOUISIANA

**State Department of Health**—Emma Maurin, Director, Division of Public Health Nursing, Bureau of Parish Health Administration, New Orleans.

## MAINE

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Una Clark, City Hall, Augusta. Vice-Chairman, Mrs. Della B. Keene, 430 State Street, Bangor. Secretary, Juliette A. Giguere, City Building, Lewiston.

**State Department of Health and Welfare**—Edith L. Soule, Director, Division of Public Health Nursing, Augusta.

## MARYLAND

**State Organization for Public Health Nursing**—President, Marcie I. Wheat, 31 South Calvert Street, Baltimore. Secretary, Lillian Hiss, 2017 Bolton Street, Baltimore. Treasurer, Grace S. Volmar, Municipal Building, Baltimore, Chairman Membership Committee, Eleanor Immler, 31 South Calvert Street, Baltimore.

**State Department of Health**—Catherine Corley, Nurse Instructor, Division of Maternal and Child Health, Baltimore.

**State Nurses' Association** Paid Executive—Mrs. Blanche G. Powell, 1217 Cathedral Street, Baltimore.

## MASSACHUSETTS

**Massachusetts Organization for Public Health Nursing** (not a branch of the N.O.P.H.N.)—President, Mrs. Frederick S. Dellenbaugh, Jr., 91 Spooner Road, Chestnut Hill. Secretary, Mrs. Thomas Worcester, 205 Putman Street, Waltham. Treasurer, Ethel V. Inglis, 197 Clarendon Street, Boston. Chairman Member-

ship Committee, Mrs. S. John O'Herron, 152 Bartlette Avenue, Pittsfield.

**State Department of Public Health**—Helen Chesley Peck, Chief Consultant, Public Health Nursing, Division of Child Hygiene, State House, Boston.

**State Nurses' Association** Paid Executive—Helene G. Lee, 420 Boylston Street, Boston.

## MICHIGAN

**State Organization for Public Health Nursing**—President, Louise Knapp, Wayne University, Detroit. Secretary, Ruth Tappan, Ann J. Kellogg School, Battle Creek. Treasurer, Euphemia Cameron, Cheboygan.

**State Department of Health**—Mrs. Helen deSpelder Moore, Chief, Division of Nursing, Bureau of Child Hygiene and Public Health Nursing, Lansing.

**State Nurses' Association** Paid Executive—Olive Sewell, Capitol Savings and Loan Building, Lansing.

## MINNESOTA

**State Organization for Public Health Nursing**—President, Mrs. Gertrude Lyons, 6 B Wilder Building, St. Paul. Secretary, Pearl Shalit, 6 B Wilder Building, St. Paul. Treasurer, Alma Hovde, Department of School Hygiene, Court House, Minneapolis. Chairman Membership Committee, Ann Nyquist, University of Minnesota, Minneapolis.

**State Department of Health**—Olivia Peterson, Superintendent of Public Health Nursing, Division of Child Hygiene, Minneapolis.

**Minnesota Public Health Association**—Mabel Johnson, 11 West Summit Avenue, St. Paul. Agnes Graff Nilson, 11 West Summit Avenue, St. Paul.

**State Nurses' Association** Paid Executive—Caroline Rankiellour, 2642 University Avenue, St. Paul.

## MISSISSIPPI

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Mary D. Osborne, Jackson.

**State Board of Health**—Mary D. Osborne, Supervisor of Public Health Nursing, Division of Maternal and Child Health, Jackson.

## MISSOURI

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Phyllis M. Dacey, Rialto Building, Kansas City. Vice-Chairman, Helena A. Dunham, State Department of Health, Jefferson City. Secretary, Dorothy Sitton, 4404 Laclede, St. Louis.

**State Board of Health**—Helena A. Dunham, Director, Public Health Nursing, Jefferson City.

**State Nurses' Association** Paid Executive—Mary E. Stebbins, 1101 Waldheim Building, Kansas City.

## MONTANA

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Luella Stickney, State Board of Health, Helena. Secretary, Bernice Johnston, Box 1245, Fort Peck.

**State Board of Health**—Anna H. McCarthy, Supervisor of Public Health Nursing, Division of Child Hygiene, Helena.

**Montana Tuberculosis Association**—Henrietta Crockett, Executive Secretary, Helena.

**State Nurses' Association** Paid Executive—Edith L. Brown, Box 928, Helena.

## NEBRASKA

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Juvia Adams, 626 Electric Building, Omaha. Secretary, Kate Lincoln, 626 Electric Building, Omaha.

**State Department of Health**—Jeanette Shafer, Public Health Nursing Consultant, Omaha.

## NEVADA

**State Board of Health**—Mrs. Christie A. Thompson, State Advisory Nurse, Division of Child Hygiene, 12 Fordonia Building, Reno. (On leave)

## NEW HAMPSHIRE

**Section on Public Health Nursing** of Graduate Nurses' Association—Chairman, Mrs. Zephyrine Hasham, Claremont. Secretary, Mrs. Mary Cary, Lancaster.

**State Board of Health**—Mrs. Mary D. Davis, Director, Division of Public Health Nursing, Concord.

**State Board of Education**—Elizabeth M. Murphy, Supervisor of Health, Concord.

## NEW JERSEY

**State Organization for Public Health Nursing**—President, Hettie W. Seifert, 1301 Union County Courthouse, Elizabeth. Corresponding Secretary, Evelyn T. Walker, 131 Pearl Street, Red Bank. Treasurer, Grace P. Renshard, State House, Trenton. Chairman Membership Committee, Emily Lydon, 42 Park Place, Newark.

**State Department of Health**—Alice Boyer, Supervisor of Nurses, Bureau of Maternal and Child Health, Trenton.

**State Department of Public Instruction**—Lulu P. Dilworth, Associate in Health and Safety Education, 1302 Trenton Trust Company Building, Trenton.

**State Nurses' Association** Paid Executive—Arabella R. Creech, 17 Academy Street, Newark.

## NEW MEXICO

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Mrs. Esther Schaubel, Roswell. Secretary, Amanda Metzger, Acoma.

**State Department of Public Welfare**—Mrs. Fannie Titsworth Warncke, Director of Public Health Nursing, Santa Fe.

## NEW YORK

**Section on Public Health Nursing** of State Nurses' Association — Chairman, Jean M. Henry, Wellington Hotel, Albany. Vice-Chairman, Elizabeth Phillips, Westchester County Department of Health, White Plains. Secretary, Beatrice Heaton, 105 East 22 Street, New York.

**State Department of Health**—Marion W. Sheahan, Director, Division of Public Health Nursing, Albany.

**State Education Department**—Marie Swanson, State Supervisor of School Nursing, State Education Building, Albany.

**State Nurses' Association** Paid Executive—Emily J. Hicks, 152 Washington Avenue, Albany.

## NORTH CAROLINA

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Lillian Bayley, Department of Health, Asheville. Secretary, Mary Ann Crockett, Board of Health, Greenville.

**State Board of Health**—Josephine L. Daniel, Public Health Nursing Consultant, Division of County Health Work, Raleigh.

## NORTH DAKOTA

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Olive Lee, State Health Department, Bismarck. Vice-Chairman, Anna Bessette, Manning. Secretary, Florence Ferguson, Finley.

**State Department of Health**—Margrete Skaarup, Supervisor of Public Health Nursing, State Capitol, Bismarck.

## OHIO

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Anne Doyle, Public Health League, City Building, Hamilton. Vice-Chairman, Mrs. Carrie Lewis, Room 117, City Hall, Cleveland. Secretary, Retta Clark, 1903 Monroe Street, Toledo.

**State Department of Health**—S. Gertrude Bush, Chief, Division of Public Health Nursing, Columbus.
**State Nurses' Association** Paid Executive—Mrs. E. P. August, 50 East Broad Street, Columbus.

## OKLAHOMA

**State Organization for Public Health Nursing**—President, Mrs. Barbara Young, 312 West Blackwell, Blackwell. Secretary, Helen Louise Richardson, 422 Wright Building, Tulsa. Treasurer, Mrs. Harriet Bookstore, 1536 Northeast 24 Street, Oklahoma City. Chairman Membership Committee, Jessie Younger, Box 921, Wewaka.
**State Department of Public Health**—Mrs. Odessa Winters, Acting Supervisor of Public Health Nursing, Division of Maternal and Child Health, Oklahoma City.

## OREGON

**State Organization for Public Health Nursing**—President, Jeanne Gallien, 1008 Southwest Sixth Avenue, Portland. Vice-President, Amy Erickson, Astoria. Secretary, Mrs. Ruth Fletcher, 205 South Church Street, Salem. Treasurer, Vera Wallace, 1008 Southwest Sixth Avenue, Portland. Chairman Membership Committee, Olive Whitlock, 816 Oregon Building, Portland.
**State Board of Health**—Olive M. Whitlock, Director, Division of Public Health Nursing, 816 Oregon Building, Portland.
**Oregon Tuberculosis Association**—L. Grace Holmes, 2248 Northwest Hoyt Street, Portland, Elsie Witchen, 1949 Northwest Everett Street, Portland.
**State Nurses' Association** Paid Executive—Mrs. Linnie Laird, 304 Stevens Building, Portland.

## PENNSYLVANIA

**State Organization for Public Health Nursing**—President, Harriet F. Young, Visiting Nurse Association, Wilkes-Barre. Secretary, Vesta M. Miller, Visiting Nurse Association, Lancaster. Treasurer, Helen V. Stevens, Visiting Nurse Association, Pittsburgh. Chairman Membership Committee, Elizabeth Bowers, 627 South Front Street, Harrisburg.
**State Department of Health**—Alice M. O'Halloran, Director, Bureau of Public Health Nursing, Harrisburg.
**State Department of Public Instruction**—Mrs. Lois Owen, School Nursing Adviser, Harrisburg.
**Pennsylvania Tuberculosis Society**—Frances H. Meyer, 311 South Juniper Street, Philadelphia.
**State Nurses' Association** Paid Executive—Esther R. Entriken, 400 North Third Street, Harrisburg.

## RHODE ISLAND

**State Organization for Public Health Nursing**—President, Candace Seeley, Burrillville District Nursing Association, Pascoag. Secretary, Ruth C. M. Anderson, 30 Rolfe Street, Auburn. Treasurer, Margaret Fogarty, Burrillville District Nursing Association, Pascoag. Chairman Membership Committee, Mrs. Catherine Tracy, 100 North Main Street, Providence.
**State Department of Health**—Edith M. Budlong, Acting Director, Public Health Nursing, Providence.
**State Nurses' Association** Paid Executive—Annie M. Earley, 381 Angell Street, Providence.

## SOUTH CAROLINA

**Committee on Public Health Nursing** of State Nurses' Association—Chairman, Mrs. Blanche R. Speed, County Nurse, Abbeville.
**State Board of Health**—Mrs. Ruth George, Public Health Nursing Consultant, Division of County Health Work, Columbia.
**State Nurses' Association** Paid Executive—Nellie C. Cunningham, 306 Carolina Life Building, Columbia.

## SOUTH DAKOTA

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Audrey Wilkinson, Milesville. Vice-Chairman, Evelyn Donavan, Mitchell. Secretary, Etta Weiss, Watertown. (As of December 1, 1936)
**State Board of Health**—Mrs. Florence Walker Englesby, Chief Consulting Nurse, Division of Child Hygiene, Pierre.

## TENNESSEE

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Bertha Knipfer, Peabody College, Nashville. Vice-Chairman, Evelyn Werdehoff, 307 Medical Arts Building, Nashville. Secretary, Mrs. Margaret Johnson, Health Department, Knoxville.
**State Department of Health**—Frances F. Hagar, Director of Public Health Nursing, Nashville.
**State Nurses' Association** Paid Executive—Nina E. Wootton, 414 Cotton States Building, Nashville.

## TEXAS

**State Organization for Public Health Nursing**—President, Mrs. E. M. Brown, San Angelo. Secretary and Treasurer, Mrs. Nettie Kirchhoff, Box 565, Panhandle. Chairman Membership Committee, Helen Le Lacheur, 700 Brazos Street, Austin.
**State Department of Health**—Marie A. Jacobson, State Supervising Nurse, Division of Child Hygiene, Austin.
**Texas Tuberculosis Association**—Helen Le Lacheur, 700 Brazos Street, Austin.
**State Nurses' Association** Paid Executive—A. Louise Dietrich, 1001 East Nevada Street, El Paso.

## UTAH

**State Organization for Public Health Nursing**—President, Jeanette Rosenstock, 431 First Avenue, Salt Lake City. Secretary, Mrs. Marjorie McDermaid, 205 Iowa Avenue, Salt Lake City. Treasurer and Chairman Membership Committee, Mrs. Pauline Hamilton, 369 I Street, Salt Lake City.
**State Board of Health**—Lily Hagerman, Director, Division of Public Health Nursing, Salt Lake City.
**Utah Tuberculosis Association**—Ada Taylor Graham, 986 Third Avenue, Salt Lake City.

## VERMONT

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Clara Pierter, Waterbury. Secretary, Beda A. Gray, 4 Baird Street, Montpelier.
**State Department of Public Health**—Nellie M. Jones, Director, Division of Public Health Nursing, Burlington.
**Vermont Tuberculosis Association**—Beda A. Gray, 4 Baird Street, Montpelier. Evelyn Collins, Springfield. Florence Perry, Wallingford. Constance E. Galaise, 348 College Street, Burlington.

## VIRGINIA

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Carrie Mae Copenhaver, 1706 Elmsmere Avenue, Richmond. Vice-Chairman, Byrd McGavock, Jonesville. Secretary, Mrs. Lurie Kirkland, Health Department, Lexington.
**State Department of Health**—Mary I. Mastin, Director, Bureau of Public Health Nursing, Richmond.
**State Nurses' Association** Paid Executive—Mrs. Jessie Wetzel Faris, 3015 East Broad Street, Richmond.

## WASHINGTON

**State Organization for Public Health Nursing**—President, Mrs. Stella Parrish, 8235 Fifteenth

Avenue, Seattle. Secretary, Dorothy Ekholm, 1729 Twelfth Avenue, Seattle. Treasurer, Anna Carlson, Court House, Mt. Vernon. Chairman Membership Committee, Minerva Blegen, Court House, Spokane.

**State Department of Health**—Anna R. Moore, State Advisory Nurse, Division of Public Health Nursing, Seattle.

**State Nurses' Association** Paid Executive—Cora E. Gillespie, 327 Cobb Building, Seattle.

### WEST VIRGINIA

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Mrs. Grayce S. Hoke, City School of Music, Charleston. Vice-Chairman, Grace Paynter, Hollidays Cove. Secretary, Mrs. Mattie Clark, 109 Crawford Street, Beckley.

**State Department of Health**—Mrs. Laurine Fisher, Director, Bureau of Public Health Nursing, Charleston.

**State Nurses' Association** Paid Executive—May A. Maloney, 55 Capital City Bank Building, Charleston.

### WISCONSIN

**Section on Public Health Nursing** of State Nurses' Association—Chairman, Rose Jahimiak, 927 Denton Street, La Crosse. Vice-Chairman, Mary Flanigan, 522 Hayes Street, Beloit. Secretary, Alice Dillon, Washburn.

**State Board of Health**—Cornelia Van Kooy, Director, Bureau of Public Health Nursing, State Capitol, Madison.

**Wisconsin Anti-Tuberculosis Association**—Doris Kerwin, 1018 North Jefferson, Milwaukee.

**State Nurses' Association** Paid Executive—Mrs. C. D. Partridge, 3727 East Layton Avenue, Cudahy.

### WYOMING

**Wyoming Organization for Public Health Nursing** (not a branch of the N.O.P.H.N.)—Chairman, Valarie Rittenhouse, University of Wyoming, Laramie. Secretary, Mrs. Hays, Rawlins.

**State Board of Health**—Mrs. Ethel G. Harris, State Supervisor of Public Health Nursing (on leave of absence). Frances Hersey, Orthopedic Nurse, Cheyenne.

**Wyoming Tuberculosis Association**—Mrs. Bess Watt, 534 Boyd Building, Cheyenne.

## TERRITORIAL POSSESSIONS

### ALASKA

**Territorial Health Department**—Mrs. Mary Keith Cauthorne, Advisory Maternal and Child Health Nurse, Juneau.

### HAWAII

**Territorial Board of Health**—Mary Williams, Director, Bureau of Public Health Nursing, Box 3378, Honolulu.

**Nursing Department,** Palama Settlement—Amy MacOwan, Director, Honolulu.

## DIRECTORS OF COURSES IN PUBLIC HEALTH NURSING MEETING THE REQUIREMENTS OF THE N.O.P.H.N.

California—Ruth W. Hay, Assistant Professor, Division of Nursing Education, University of California, Berkeley.

District of Columbia—Mary C. Connor, Director, Public Health Nursing Division, School of Nursing, Catholic University of America, Washington.

Massachusetts—Marjory Stimson, Assistant Professor of Public Health Nursing, School of Nursing, Simmons College, 300 The Fenway, Boston.

Michigan—Mrs. Barbara H. Bartlett, Professor of Public Health Nursing, Department of Public Health Nursing, University of Michigan, Ann Arbor. Louise Knapp, Professor of Nursing, Department of Nursing, Wayne University, 4841 Cass Avenue, Detroit.

Minnesota—Margaret Arnstein, Director, Department of Preventive Medicine and Public Health, University of Minnesota, Minneapolis.

New York—Lillian A. Hudson, Professor of Nursing Education, Teachers College, Columbia University, New York. Ann Doyle, Director, Public Health Nursing Course, School of Sociology and Social Service, Fordham University, New York. Ellen L. Buell, Professor of Public Health Nursing, College of Medicine, University of Syracuse, Syracuse.

Ohio—Marion G. Howell, Professor of Public Health Nursing, School of Applied Social Sciences, Western Reserve University, Cleveland.

Oregon—Elnora E. Thomson, Professor of Public Health Nursing, Department of Nursing Education, Medical School, University of Oregon, Portland.

Pennsylvania—Katharine Tucker, Professor of Public Health Nursing, Department of Nursing Education, School of Education, University of Pennsylvania, Philadelphia.

Tennessee—Aurelia B. Potts, Director, Department of Nursing Education, George Peabody College for Teachers, Nashville. Lucy Gordon White, Assistant Professor of Public Health Nursing, School of Nursing, Vanderbilt University, Nashville.

Virginia—Lillian Bischoff, Director of Public Health Nursing Course, School of Nursing, Medical College of Virginia, Richmond. Frances C. Montgomery, Professor of Public Health Nursing, Richmond School of Social Work and Public Health Nursing, 901 West Franklin Street, Richmond.

Washington—Mrs. Elizabeth S. Soule, Professor of Public Health Nursing, School of Nursing Education, University of Washington, Seattle.

Territory of Hawaii—Amy MacOwan, Director of Public Health Nursing Course, University of Hawaii, Honolulu.

## JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY, BOSTON, MASS.

*Nursing Supervisors*

Director, Sophie C. Nelson.
Assistant Director, Agnes V. Murphy.
Assistant to the Director, Ethel V. Inglis.
Assistant to the Director, Katharine E. Peirce.

## METROPOLITAN LIFE INSURANCE COMPANY, NEW YORK, N. Y.

*Nursing Director and Superintendents*

Alma C. Haupt, Director of the Nursing Bureau, Welfare Division, 1 Madison Avenue, New York, N. Y.

Mrs. Helen C. LaMalle, Superintendent of Nursing, 600 Stockton Street, San Francisco, Calif.

Alice Ahern, Assistant Superintendent of Nursing, 180 Wellington Street, Ottawa, Ontario, Canada.

Marie L. Johnson, Assistant Director of Nursing Bureau, Welfare Division, 1 Madison Avenue, New York, N. Y.

Margaret Reid, Educational Director, Welfare Division, 1 Madison Avenue, New York, N. Y.

Ruth C. Waterbury, Group Nursing Assistant, Welfare Division, 1 Madison Avenue, New York, N. Y.

Mary Harrigan, Area Supervisor, Welfare Division, 1 Madison Avenue, New York, N. Y.

Mrs. Irene McCullough, Area Supervisor, Welfare Division, 1 Madison Avenue, New York, N. Y.

*Territorial Supervisors and Territory*
*(All to be addressed at 1 Madison Avenue, New York, N. Y.)*

Grace Anderson—Atlantic Coast and Metropolitan Territories.

Henrietta Bonheyo—Southern Territory.

Mrs. Eva D. Calhoun—Great Eastern Territory.

Hortense E. Gruber—New England Territory.

Margaret Leddy—Central Territory.